PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
		15G225	B. WING		01/08	3/2013
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP CODE		
OCCAZ	IO INC		2234 Q	AVE ASTLE, IN 47362		
				ASTLE, IN 47302		_
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	` `	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O THE APPROPRIATE	
W0000						
	This visit was	for a fundamental annual	W0000			
	recertification and state licensure survey.					
		ey: December 10, 11, 12,				
	13, 14, 17, 21, 27, 2012, January 7, and 8,					
	2013.					
	Provider Numl					
	Facility Numb					
	AIM Number:	100243360				
	Surveyors:					
		t, Medical Surveyor				
	III/QMRP	t, Wedical Bulveyor				
	-	Public Health Nurse				
	Surveyor III	dono frontin i varse				
	These federal of	deficiencies also reflect				
		n accordance with 460 IAC				
	9.					
		completed 1/11/13 by Ruth				
	Shackelford, Med	dical Surveyor III.				
			1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2013		
NAME OF P OCCAZIO (X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		STREET A	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W0120	SOURCES The facility must a services meet the Based on observed of 1 incident of behavior for clie outside workshop needs. Findings include The facility's recentled of 1:15 AM. The facility's recentled on 6/15/12 at 12:15 at 12	ords were reviewed on 12/11/1 facility's BDDS (Bureau of Disabilities Services) records in 240 PM while at the workshop of vorkstation." The report indicate the bathrooms, all of the main Hab rooms and the outside periods of workshop]. [Client #7] could not be of workshop] staff started an of cor [client #7]." The report indicated at 12:52 PM at a local grocer ersuaded to get into staff's car a sup home. The report indicated to 15 minute checks per client #7 at Plan. The properties of 6/21/12 indicates ments be prevented? [Client #7 ecks. This behavior is addressed to plan. We have had a meeting wind we will give [client #7] extractions.	WOJ	20	W 120 Services Provided with Outside Sources The facility must assume that outside services meet the needs of each client. 1. What corrective action will be accomplished? Client #7's behavior plan will be revised to include 15 minute checks due to his supervision concerns. An AWOL risk plan will be developed for Client #7. An IDT will be held with workshop on 1-30-13 for Clien to discuss his need for supervision while at work. Client #7's IPOP assessments will be revised to reflect his supervision needs. Client #7's behavior plan will be revised to include elopement as a targeted behavior.	e n be t #7	02/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 2 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED
		15G225	B. WIN			01/08/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		2234 Q AVE			
OCCAZIO	O INC		NEW CASTLE, IN 47362			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					2. How will we identify oth	ı
	On 12/11/12 froi	m 10:35am until			residents having the potentia	1
	12:20pm, observ	rations and interviews			to be affected by the same	
	-	at the workshop. From			deficient practice and what	
	•	2noon, client #7 walked			corrective action will be take	n?
		ne workshop area, walked			· All residents have the	
		ne break area, and walked			potential to be affected by the	
		, , , , , , , , , , , , , , , , , , ,			same deficient practice.	
	from one classroom to the next					_
	classroom. Client #7 walked into and out of offices in the front area of the workshop and the lobby area. During the				The IPOP assessments	tor
					all of the residents will be reviewed and supervision need	10
					updated as necessary.	15
	period from 10:35am until 12noon client #7 was not monitored by the workshop				apadica de necessary.	
					· The supervision needs of	of
	staff to prompt h	im to activity or			all of the residents at the Q	
	monitoring clien	t #7's location within the			Avenue group home will be	
	workshop. At 1	1:25am, client #7's			reviewed with workshop.	
	Workshop Super	visor (WKS) indicated			The behavior plans for t	he
		or the facility staff to			residents will be reviewed and	
	_	client #7's blood sugar.			updated as necessary.	
		e check for [client #7's]				
		nce in a while. If we have			 Risk plans for the reside will be reviewed and updated a 	
	_	lking around." The WKS			15	
		umented 15 minute			necessary.	
		ilable for review.				
	checks were avai	liable for review.				
	0 10/10/10	0.55			1.What measures will be pu	t
		0:55am, an interview			into place or what systemic	
	`	PD (Qualified Mental			changes will be made to	
		essional/Program			ensure that the deficient practice does not recur?	
	Director) and the	e RC (Residential			p. 40000 4000 1100 10001 1	
	Coordinator) wa	s conducted. The			· The IPOP assessments	for
	QMRP/PD indic	ated client #7 should			all of the residents will be	
	have been monitored every 15 minutes.				reviewed and supervision need	ds
		d client #7 should be kept			updated as necessary.	
	within eyesight s	•			The supervision needs of	of

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G225	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/08/2013
NAME OF F	PROVIDER OR SUPPLIER	2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	QMRP/PD indicated client #7 was on 15 minute checks because of his unstable blood sugars and non-compliance with his diet.		all of the residents at the Q Avenue group home will be reviewed with workshop. The behavior plans for the second	the
	Client #7's record was reviewed on 12/12/12 at		residents will be reviewed and updated as necessary.	• • • • • • • • • • • • • • • • • • •
	The client's IPOP (Individual Plan of Protective Oversight - Residential Information) of 8/17/11 client #7 "has gone AWOL (absent without leav since living in the group home so he must be clemonitored at all times." The 8/17/11 record indi		Risk plans for the reside will be reviewed and updated necessary.	• • • • • • • • • • • • • • • • • • •
	client was on "15 minute checks during hours of and asleep." Client #7's Case Conference Minut 6/18/12 indicated a review of the BDDS report 6/14/12 with no changes made to the client's plant #7's 4/2012 Paleswier Management Plant		1.How will the corrective action be monitored to ensure the deficient practice will not recur?	
	Client #7's 4/2012 Behavior Management Plan (did not include documented interventions of 15 monitoring checks. Client #7's 4/2012 BMP inc while in the community client #7 was to be with eyesight supervision.		The RC will monitor on regular basis while at worksho and daily when in the home. The Program Specialist monitor as she completes her	qq
	9-3-1(a)		audits. 1.What is the date by which the systemic changes will be	
			completed? · February 7 th , 2013	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2013	
NAME OF POCCAZION (X4) ID		TATEMENT OF DEFICIENCIES		STREET A	ASTLE, IN 47362		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
W0130	The facility must of clients. Therefore privacy during trepersonal needs. Based on observe of 1 client (client administered at the facility staff, the privacy during must be findings included. On 12/11/12 at 1 Direct Care Staff workshop through client #7 sat at a area. At 12noon clear plastic unlocked clear push workshop floor a unlocked clea	2noon, the facility's f (DCS) #3 entered the the front door where table in the front lobby, DCS #3 set down a coked box on the table in and walked onto the table in LCS #3 left the lastic box out of DCS	W0	130	W 130 Protection of Clients Rights The facility must ensure the right of all clients. Therefore, the facility must ensure privacy dustreatment and care of personal needs. 1. What corrective action will be accomplished? Client #7 will be put on programming to understand the importance of needing his privice while taking his insulin. A meeting will be held we workshop on 1-30-13 to discuss the need to encourage Client #1 and staff to administer his medication in privacy. A staff meeting will be held no 1-30-13 to discuss the importance of ensuring resident privacy when providing treatment and care of personal needs, including insulin administration Client #7.	ring I e acy vith ss #7 eld nt ent	02/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 5 of 105

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/08/2013		
	X (EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ST 2: N	234 Q A IEW CA D EFIX AG	DDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) 2. How will we identify oth		(X5) COMPLETION DATE
	administered clifront lobby area Between 12:10p twenty-one (21) staff, and works and walked thro was taught or er On 12/12/12 at with the QMRP, Retardation Proportion and th Coordinator) wa QMRP/PD and client #7 should his medication a	chest, and DCS #3 ent #3's insulin in the of the workshop. m and 12:20pm, people: clients, visitors, hop staff entered, exited, ugh the lobby. No privacy acouraged by DCS #3. 10:55am, an interview /PD (Qualified Mental fessional/Program e RC (Residential as conducted. The the RC both indicated be given privacy during administration and staff mpted him to a closed medication			residents having the potential to be affected by the same deficient practice and what corrective action will be take All residents have the potential to be affected by the same deficient practice. A meeting will be held we workshop on 1-30-13 to discuss the need to ensure privacy who providing treatment and care of personal needs, including insuladministration. A staff meeting will be hon 1-30-13 to discuss the importance of ensuring resider privacy when providing treatment and care of personal needs, including insulin administration. The RC will monitor and implement programming for the residents to ensure that they understand their need for privative during treatment and personal care needs. As their needs change, the RC will ensure that they update their ISP, IPOP's implement training goals to address the concerns. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?	n? vith ss en of lin eld nt ent acy at and	

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	F OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00	COMPLETED 01/08/2013		
NAME OF PI	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				A meeting will be held workshop on 1-30-13 to disct the need to ensure privacy w providing treatment and care personal needs, including insadministration. A staff meeting will be on 1-30-13 to discuss the importance of ensuring reside privacy when providing treatment care of personal needs, including insulin administration. The RC will monitor are implement programming for the residents to ensure that they understand their need for privating treatment and personal care needs. As their needs change, the RC will ensure the they update their ISP, IPOP's implement training goals to address the concerns.	uss hen of sulin held ent ment on. id he wacy al		
				1.How will the corrective action be monitored to ensu the deficient practice will no recur? The RC will monitor or daily basis when they are in thome and at workshop. The Program Specialis monitor as they complete the audits.	ot n a rhe st will		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 7 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLI - 01/08/2	ETED		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE					
OCCAZIO	O INC			ASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE		
				5. What is the date the systemic changes completed?				
				· February 7 th , 20	013			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 8 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225			A. BUILDING B. WING			COMPLETED 01/08/2013	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
				INLVV			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0149	The facility must of written policies ar	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client.	WO	149	W 149 Staff Treatment of Clients The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abust the client. 1. What corrective action will be accomplished? The RC for the home wibe retrained on the importance notifying the administrator time and on investigating incidents unknown injuries, peer to peer aggression, use of restraint an suspected abuse and neglect. Staff will be retrained or Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13. Staff will be trained on he to properly secure wheelchairs using the tie downs in the bust that transports the residents of 1-30-13.	e of ill e of ely of od n e, eir	02/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 9 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G225	B. WING		01/08/2013	
NAMEGER	DOLUDED OF GURES TO			ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIE	±K	2234 0	QAVE		
OCCAZIO	O INC		NEW (CASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG			
				residents having the potential to be affected by the same	ai	
				deficient practice and what		
				corrective action will be take	n?	
				· All residents have the potential to be affected by the		
				same deficient practice.		
				production production.		
				The RC for the home w		
				be retrained on the importance		
				notifying the administrator time and on investigating incidents		
				unknown injuries, peer to peer		
				aggression, use of restraint an		
				suspected abuse and neglect.		
				Staff will be retrained or		
				 Staff will be retrained or Occazio's policy #2105 Abuse 	•	
				Neglect and Exploitation at the		
				staff meeting on 1-30-13.		
				0. " "		
				 Staff will be trained on he to properly secure wheelchairs 		
				using the tie downs in the bus		
				that transports the residents o		
				1-30-13.		
				3. What measures will be		
				put into place or what system	nic	
				changes will be made to ensure that the deficient		
				practice does not recur:		
				p. 301100 4000 1101 100411		
				· The RC for the home wi	ill	
				be retrained on the importance	•	
				notifying the administrator time		
I	I			and on investigating incidents	of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 10 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUILDING B. WING		COMPLETED 01/08/2013				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				unknown injuries, peer to peer aggression, use of restraint ar suspected abuse and neglect.	nd			
				Staff will be retrained of Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13.),			
				Staff will be trained on I to properly secure wheelchairs using the tie downs in the bus that transports the residents of 1-30-13	S			
				4. How will the corrective action be monitored to ensu the deficient practice will no recur?				
				 The RC will monitor on daily basis when they are in the home. 				
				The Program Specialist monitor as they complete their audits.				
				5. What is the date by whi the systemic changes will be completed?				
	1 of 2 allegations	ew and record review for s of neglect/abuse for ility failed to implement		February 7 th , 2013				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 11 of 105

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
		15G225	A. BUII B. WIN	LDING		01/08/	
			B. WIIV		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIER	R.	2234 Q AVE				
OCCAZI	O INC			NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		et policy to immediately		1710	·		DATE
	report allegations of						
		istreatment to the					
	administrator an	d to BDDS (Bureau of					
	Developmental I	Disability Services) in					
	accordance with state law.						
		1 1 2					
		ew and record review for					
		inknown origin for client					
	#4, for 1 of 2 allegations of neglect/abuse for client #2 and for 1 of 1 incident of						
	client to client abuse in regards to client						
		ailed to ensure all injuries					
		in and allegations of					
	abuse/neglect we	ere investigated and/or					
	thoroughly inves	stigated.					
	Based on intervi	ew and record review for					
	1	ion reviewed, the facility					
		ent its Abuse/Neglect					
	policy to report t						
	_	the administrator within 5					
	"	regards to an unknown					
	injury for client	#4 .					
	Findings include	::					
	1. Interview with	n DCS (Direct Care Staff)					
		at 6:40 PM indicated					
		electric wheelchair and					
	I -	heelchair going too fast,					
		run into things. DCS #13					
stated "a few months ago" while client #2							
	was on a visit at	a lake with his father, the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 12 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225			LDING	NSTRUCTION 00	(X3) DATE COMPI 01/08	LETED
NAME OF E	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	ran his wheelcha boat dock. DCS and his wheelchar client #2's father and the wheelchar #13 stated client if his father had The facility's rec 12/11/12 at 11:1 records did not it client #2 having water due to his a boat dock with wheelchair. The indicate an invest client #2 having water due to his a boat dock with wheelchair. Interview with the Coordinator on indicated client #2 having water due to his a boat dock with wheelchair. Interview with the Coordinator on indicated client #3 mobility, was not and could not swas aware of the and his father. The not report the indicate the time of the report it to BDD	ords were reviewed on 5 AM. The facility indicate an incident of to be rescued from the wheelchair running off of client #2 sitting in the facility records did not stigation in regards to to be rescued from the wheelchair running off of client #2 sitting in the wheelchair running off of client #2 sitting in the incident #2 sitting in the incident #2 PM #2 used a wheelchair for the able to stand on his own from the RC indicated he incident with client #2 incident to the administrator is incident nor did he incident incident since incident since					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 13 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
THEFTERN	or condition	15G225		LDING		01/08/	
		100220	B. WIN		DDDEGG CITY CTATE ZID CODE	0 17 0 07	2010
NAME OF I	PROVIDER OR SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
	7 The facility's	na a a m da verama marri avera d' a m					
	I -	records were reviewed on					
		5 AM. The facility's					
	General Event K	eports indicated:					
	On 5/27/12 cl	ient #4 had a "bruised					
		eport indicated the origin					
	1 -	s unknown. The record					
	indicated the RC	had asked 3 staff if they					
	knew what had h	nappened to client #4. The					
	record did not in	dicate any client					
interviews or interviews of all DCS that							
	worked in the ho	ome. The facility records					
	did not indicate	the results of the					
	investigation had	d been reported to the					
	administrator.	•					
	On 10/18/12 t	wo DCS were taking					
	clients #1, #2, #3	3, #4, #5 and #6 to the					
	workshop via the	e facility van. The DCS					
	"heard a big thuc	d" and "realized" client #2					
	had "fallen over	in his wheelchair." The					
		of the van "got up and					
	went back there	to be with him until the					
		a safe place to pull					
	over." Once the	van was stopped, the					
	DCS "had to ope	en up the wheelchair ramp					
	because he (clien	nt #2) was wedged in					
		p and his (client #2's)					
	chair." The report	rt indicated once there					
	was enough roor	n the DCS sat client #2					
	up and "proceed	ed to pick him (client #2)					
	up and put him (client #2) back in his					
	(client #2's) chai	r." The report indicated					
	•						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 14 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

-	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUII	A. BUILDING B. WING		COMPLETED 01/08/2013	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	the DCS could te injured "because laughing" and "d The report indicate proceeded on to facility records d investigation was The facility's I Disabilities Servindicated on 5/21 consumers were like they were beconsumers asked act like his body, he was teasing. [headphones and consumers on the headphones. One was red and the chad no red mark, held down one meto prevent him from the facility reconsumers with the provided for revicient #4's injury been investigated.	ell client #2 was not he (client #2) was id not say he was hurt." itted the DCS then the workshop. The id not indicate an is conducted. Bureau of Developmental ices (BDDS) records id 1/12 "Two male playing around acting oxing. One of these male iclient #6] if he would guard and protect him but Client #6] ripped off his hit both of the male eir left shoulder with his e consumer's shoulder other consumer's shoulder "Client #6's arms "were ninute until he was calm om hitting other clients." rds did not indicate an is conducted. The RC on 12/13/12 at 4 investigations had been ew. The RC indicated of unknown origin had it. "I talked to the three					
	indicated he had	n duty that day." The RC not interviewed clients 5, #6 and #7 or all the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 15 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE COMPL		
ANDILAN	OF CORRECTION	15G225		LDING	00	01/08/	
		100220	B. WIN			0 17007	2010
NAME OF I	PROVIDER OR SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
TAG		with client #2 in the		TAG	BEFFEERET		DATE
		e RC indicated he had not					
		e RC indicated he had not allts of the investigation of					
	_	nown origin to the					
		he RC indicated he did					
		to investigate the incident 10/18/12 because the					
		a rolling to the rolling rolli					
		t have been unlatched."					
	the buckles must	nave been unlatched."					
	Interview with the	ne PS (Program					
Specialist) on 12/13/12 at 4 PM indicated		` `					
		known origin were to be					
	1	stigated. The PS indicated					
	1	conducted a thorough					
		regards to client #4's					
		vn origin. The PS					
	1 " "	ident of 10/18/12 "should					
	have been invest						
	Review of the 1/	1/11 facility policy of					
	"Suspected Abus						
		oorting" on 12/11/12 at 1					
	PM indicated:						
		ust report immediately by					
	1 —	any incident of suspected					
		nd/or exploitation of a					
	_	er. The RC will report by					
		ations of abuse, neglect					
	_	APS (Adult Protective					
	_	e District and Central					
	offices of the BI						
		Disabilities Services)					
	•	of receipt of suspected					
		- *					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 16 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

		CATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 01/08/2013			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST I REGULATORY OR LSC IDENT	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	abuse, neglect and/or expAll injuries of unknow reported to the Director at thoroughly investigated. the investigation will be Director within 5 businesNeglect to be defined provide the proper care for resident/consumer, in a to causing the resident/consphysical or emotional strumreasonable delays in proper appropriate services, incomedication errors, are consumed when they cause the resident undue physical or emotion injury. 9-3-2(a)	on origin are to be and to be The outcome of reported to the ss days. as the failure to for a simely manner, sumer undue less or injury; roviding studing insidered neglect dent/consumer						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 17 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		15G225	A. BUII B. WIN			01/08/2013	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2234 Q			
OCCAZIO) INC				ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		DATE
W0153	The facility must of mistreatment, injuries of unknow immediately to the	ENT OF CLIENTS ensure that all allegations neglect or abuse, as well as vn source, are reported e administrator or to other ance with State law ed procedures.	Wo	153	W 153 Staff Treatment of Clients The facility must ensure that a allegations of mistreatment,		02/07/2013
					neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other official in accordance with State law through established procedure	ıls	
					What corrective action will be accomplished?		
					 Staff will be retrained or Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13. 	,	
					 Staff will retrained on the incident reporting guidelines. 	е	
					The importance of notify the administrator immediately be reviewed with the RC.		
					The importance of notify their supervisor and the administrator immediately will reviewed with the staff at the Co	be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 18 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	15G225	B. WING		01/08/2013
NAME OF PI	ROVIDER OR SUPPLIER	2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			Avenue group home at the start meeting on 1-30-13. All staff members who is	
			to notify the administrator immediately will face disciplina action per Occazio's policy regarding abuse, neglect and exploitation.	ary
			2. How will we identify oth residents having the potentiato be affected by the same deficient practice and what corrective action will be taken	al
			All residents have the potential to be affected by the same deficient practice.	
			Staff will be retrained of Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13.),
			The importance of notif the administrator immediately be reviewed with the RC.	will
			The importance of notification their supervisor and the administrator immediately was reviewed with the staff at the Avenue group home at the staff meeting on 1-30-13.	s 2
			All staff members who to notify the administrator immediately will face disciplinaction per Occazio's policy	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 19 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00	COMPLETED 01/08/2013		
NAME OF P	ROVIDER OR SUPPLIEF	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				regarding abuse, neglect and exploitation.			
				3. What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur: Staff will be retrained of Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13. The importance of notif the administrator immediately be reviewed with the RC. The importance of notif their supervisor and the administrator immediately was reviewed with the staff at the Avenue group home at the staff meeting on 1-30-13. All staff members who is to notify the administrator immediately will face discipling	n e, eir ying will ying s Q aff		
				action per Occazio's policy regarding abuse, neglect and exploitation.	агу		
				4. How will the corrective action be monitored to ensu the deficient practice will no recur?	re		
				· The RC will monitor on	а		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 20 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION . DAY DIVIS			(X3) DATE S COMPL		
111,12,12,111	or conditions	15G225	A. BUII			01/08/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			2234 Q			
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	ESC IDENTIFY IN OUT OR MATION)		IAG	daily basis when they are in th		DATE
					home.	-	
					The Program Specialist monitor as they complete their audits.		
					5. What is the date by whi the systemic changes will be completed?		
					February 7 th , 2013.		
	1 of 2 incidents of client #2, the fact immediately repeabuse/neglect/mit to the administration of Developments accordance with	ort allegations of istreatment immediately tor and to BDDS (Bureau al Disability Services) in state law.					
	#13 on 12/10/12 client #2 used an would get the wl lose control and DCS #13 stated client #2 was on father, the client wheelchair and r water off of a bo	at 6:40 PM indicated at electric wheelchair, heelchair going too fast, would run into things. "a few months ago" while a visit at a lake with his was sitting in his an his wheelchair into the at dock. DCS #13 #2 and his wheelchair					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 21 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00	COMPLETED 01/08/2013			
NAME OF I	PROVIDER OR SUPPLIER D INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	were under water and client #2's father rescued both client #2 and the wheelchair from the water. DCS #13 indicated client #2 would have drowned if his father had not rescued him. The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility records did not indicate an incident of client #2 having to be rescued from the water due to his wheelchair running off of a boat dock with client #2 sitting in the wheelchair was reported to the administrator. Interview with the RC (Residential Coordinator) on 12/12/12 at 2 PM indicated client #2 used his wheelchair for all mobility, could not stand on his own or swim. The RC indicated he was aware of the incident with client #2 and his father. The RC indicated he did not report the incident to the administrator at the time of the incident nor did he report it to BDDS because the RC did not think it was a reportable incident since client #2 was with his father. 9-3-2(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 22 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			COMPL		
		15G225	A. BUII B. WIN			01/08/2013	
NAME OF F	PROVIDER OR SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0154		ENT OF CLIENTS have evidence that all are thoroughly	W0	154	W 154 Staff Treatment of Clients The facility must have evident that all alleged violations are thoroughly investigated. 1. What corrective action will be accomplished? Staff will be retrained on Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13. Staff will retrained on the incident reporting guidelines at the investigation process. The importance of following the investigation process will be reviewed with RC. All staff members who to notify the administrator immediately will face disciplina action per Occazio's policy regarding abuse, neglect and exploitation.	n e, eir ne and the fail ary	02/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 23 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUILDING B. WING		COMPLETED 01/08/2013		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	residents having the potentia to be affected by the same deficient practice and what corrective action will be taked. All residents have the potential to be affected by the same deficient practice. Staff will be retrained on Occazio's policy #2105 Abused Neglect and Exploitation at the staff meeting on 1-30-13. Staff will retrained on the incident reporting guidelines at the investigation process. The importance of following the investigation process will be reviewed with RC. All staff members who is to notify the administrator immediately will face discipling action per Occazio's policy regarding abuse, neglect and exploitation.	DATE al en? n e, eir le and the		
				3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: Staff will be retrained or Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13.	n o,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 24 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUILDING B. WING	COMPLETED 01/08/2013			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				Staff will retrained on the incident reporting guidelines at the investigation process. The importance of following the investigation process will be reviewed with	ind	
				RC. All staff members who f to notify the administrator immediately will face disciplina action per Occazio's policy regarding abuse, neglect and exploitation.		
				4. How will the corrective action be monitored to ensure the deficient practice will not recur? The RC will monitor on	t	
				daily basis when they are in the home. The Program Specialist monitor as they complete their audits.	will	
				5. What is the date by whi the systemic changes will be completed? February 7 th, 2013		
	Based on intervio	ew and record review for				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 25 of 105

STRIEST ADDRESS, CITY, STATE, ZIP CODE. 2234 Q AVE NEW CASTLE, IN 47362 ID REFERN (EACH DEFICENCY MUST BE PRECEDED BY PLL) TAG REQUIATORY OF ITS IDENTIFYING INFORMATION 1 of 1 injury of unknown origin for client #4, for 1 of 1 allegation of neglect/abuse for client #2 and for 1 of 1 incident of client to client abuse in regards to client #6, the facility failed to ensure all injuries of unknown origin and allegations of abuse/neglect were investigated and/or thoroughly investigated. Findings include: The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's General Event Reports indicated the origin of the injury was unknown. The record indicated the RC had asked 3 staff if they knew what had happened to client #4. The record did not indicate any client interviews, interviews of all DCS that worked in the home or the findings of the investigation. _On 10/18/12 two DCS were taking clients #1, #2, #3, #4, #5 and #6 to the workshop via the facility van. The DCS "heard a big thud" and "realized" client #2 had "fallen over in his wheelchair." The DCS in the rear of the van "got up and went back there to be with him until the other staff found a safe place to pull	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 08/2013	
OCCAZIO INC CALL DEFICIENCY MIST BE PRECIBED BY FILL PREFIX GACH DEFICIENCY MIST BE PRECEDED BY FILL PREFIX GACH DEFICIENCY MIST BE PRECEDED BY FILL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 1 of 1 injury of unknown origin for client #4, for 1 of 1 allegation of neglect/abuse for client to client abuse in regards to client #6, the facility failed to ensure all injuries of unknown origin and allegations of abuse/neglect were investigated and/or thoroughly investigated. Findings include:			15G225	B. WING			00/2013
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1 of 1 injury of unknown origin for client #4, for 1 of 1 allegation of neglect/abuse for client #2 and for 1 of 1 inicident of client to client abuse in regards to elient #6, the facility failed to ensure all injuries of unknown origin and allegations of abuse/neglect were investigated and/or thoroughly investigated. Findings include: The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's General Event Reports indicated: On 5/27/12 client #4 had a "bruised right eye." The report indicated the origin of the injury was unknown. The record indicated the RC had asked 3 staff if they knew what had happened to client #4. The record did not indicate any client interviews, interviews of all DCS that worked in the home or the findings of the investigation. On 10/18/12 two DCS were taking clients #1, #2, #3, #4, #5 and #6 to the workshop via the facility van. The DCS "heard a big thud" and "realized" client #2 had "fallen over in his wheelchair." The DCS in the rear of the van "got up and went back there to be with him until the other staff found a safe place to pull				2234 0	QAVE	CODE	
#4, for I of I allegation of neglect/abuse for client #2 and for I of I incident of client to client abuse in regards to client #6, the facility failed to ensure all injuries of unknown origin and allegations of abuse/neglect were investigated and/or thoroughly investigated. Findings include: The facility's records were reviewed on 12/11/12 at 11:15 AM. The facility's General Event Reports indicated: On 5/27/12 client #4 had a "bruised right eye." The report indicated the origin of the injury was unknown. The record indicated the RC had asked 3 staff if they knew what had happened to client #4. The record did not indicate any client interviews, interviews of all DCS that worked in the home or the findings of the investigation. On 10/18/12 two DCS were taking clients #1, #2, #3, #4, #5 and #6 to the workshop via the facility van. The DCS "heard a big thud" and "realized" client #2 had "fallen over in his wheelchair." The DCS in the rear of the van "got up and went back there to be with him until the other staff found a safe place to pull	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
over." Once the van was stopped, the		#4, for 1 of 1 alle for client #2 and client to client al #6, the facility fa of unknown orig abuse/neglect we thoroughly investigation. Findings include The facility's rec 12/11/12 at 11:1 General Event R _On 5/27/12 cliright eye." The rof the injury was indicated the RC knew what had be record did not in interviews, interworked in the horizotte investigation. _On 10/18/12 truly clients #1, #2, #3 workshop via the "heard a big thuch had "fallen over DCS in the rear went back there other staff found."	egation of neglect/abuse for 1 of 1 incident of buse in regards to client ailed to ensure all injuries in and allegations of ere investigated and/or stigated. cords were reviewed on 5 AM. The facility's eports indicated: ient #4 had a "bruised eport indicated the origin s unknown. The record c had asked 3 staff if they happened to client #4. The dicate any client views of all DCS that ome or the findings of the wo DCS were taking 8, #4, #5 and #6 to the e facility van. The DCS d" and "realized" client #2 in his wheelchair." The of the van "got up and to be with him until the la a safe place to pull				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 26 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE S COMPL		
ANDILLAN	OI CORRECTION	15G225		LDING		01/08/	
		100220	B. WIN		DDDEGG CHTV CT TT	3 1/00/	2010
NAME OF P	ROVIDER OR SUPPLIER			2234 Q	AVE		
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' TAG: DEFICIENCY)		TE	COMPLETION	
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		en up the wheelchair ramp nt #2) was wedged in					
	`	p and his (client #2's)					
	· ·	rt indicated once there					
	-	n the DCS sat client #2					
	•	ed to pick him (client #2)					
		client #2) back in his					
	• • •	" The report indicated the					
	` ′	lient #2 was not injured					
		ent #2) was laughing" and					
	,	vas hurt." The report					
	indicated the DCS then proceeded on to						
		he facility records did not					
	_	tigation was conducted.					
		8					
	The facility's l	Bureau of Developmental					
		ices (BDDS) records					
	indicated on 5/2	, ,					
	consumers were	playing around acting					
	like they were bo	oxing. One of these male					
	consumers asked	[client #6] if he would					
	act like his body	guard and protect him but					
	he was teasing. [Client #6] ripped off his					
	headphones and	hit both of the male					
		eir left shoulder with his					
	•	e consumer's shoulder					
		other consumer's shoulder					
		" Client #6's arms "were					
		ninute until he was calm					
	_	om hitting other clients."					
	_	rds did not indicate an					
	investigation wa	s conducted.					
	Interview with th	ne RC on 12/13/12 at 4					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 27 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225 A. BUILDING B. WING		DING	00 	COMPL 01/08/	ETED		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	PM indicated all investigations had been provided for review. The RC indicated client #4's injury of unknown origin had been investigated. "I talked to the three staff that were on duty that day." The RC indicated he had not interviewed clients #1, #2, #3, #4, #5, #6 and #7 or all the staff that worked with client #2 in the group home. The RC indicated the facility records did not include the findings of the investigation and or the outcome of the investigation. The RC indicated he did not see the need to investigate the incident with client #2 on 10/18/12 because the DCS that were involved told him "one of the buckles must have been unlatched." Interview with the PS (Program Specialist) on 12/13/12 at 4 PM indicated all injuries of unknown origin were to be thoroughly investigated. The PS indicated the RC had not conducted a thorough investigation in regards to client #4's injury of unknown origin. The PS indicated the incident of 10/18/12 "should have been investigated." 9-3-2(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 28 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G225 NAME OF PROVIDER OR SUPPLIER			(X2) M ^I A. BUII B. WIN	LDING G	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE AVE	(X3) DATE SURVEY COMPLETED 01/08/2013
OCCAZI	O INC			NEW C	CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0156	The results of all reported to the act representative or accordance with working days of the Based on intervity of 1 investigated failed to report the injury for client. Findings included The facility's recent 12/11/12 at 11:11. General Event Results 5/27/12 client #4 eye." The report the injury was used in the injury was used to coordinator) on indicated he had of the investigated regards to client injury. Interview with the Specialist of 12 she had not been accordinated to the injury.	ew and record review for ion reviewed, the facility he results of the 5 working days to the regards to an unknown #4. e: cords were reviewed on 5 AM. The facility's deports indicated on 4 had a "bruised right indicated the origin of nknown. the RC (Residential 12/13/12 at 4 PM anot reported the results ion to the administrator in #4's injury of unknown the PS (Program 2/13/12 at 4 PM indicated in notified of the results of in regards to client #4's	Wo	156	W 156 Staff Treatment of Clients The results of all investigation must be reported to the administrator or designated representative or to other officin accordance with State law within five working days of the incident. 1. What corrective action will be accomplished? Staff will be retrained or Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13. Staff will retrained on the incident reporting guidelines at the investigation process. The importance of following the investigation process will be reviewed with RC. All staff members who to notify the administrator immediately will face discipling action per Occazio's policy	cials n e, eir ne and the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 29 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G225	A. BUILDING B. WING	COMPLETED 01/08/2013
NAME OF	PROVIDER OR SUPPLIER O INC	STREET ADDRESS, CITY, STATE, ZII 2234 Q AVE NEW CASTLE, IN 47362	P CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH TAG DEFICIENCY)	SHOULD BE COMPLETION
	9-3-2(a)	regarding abuse, neg exploitation.	glect and
		2. How will we id residents having the to be affected by the deficient practice as corrective action will. All residents his potential to be affected same deficient practice. Staff will be respected and Exploital staff meeting on 1-30. Staff will retrain incident reporting guithe investigation process will be review RC. All staff members to notify the administ immediately will face action per Occazio's regarding abuse, negexploitation.	e potential e same nd what II be taken? ave the ed by the ce. trained on 05 Abuse, tion at their 0-13. ned on the idelines and cess. te of pation wed with the ers who fail trator disciplinary policy
		3. What measure put into place or wh changes will be madensure that the defi	at systemic de to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 30 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	· ·		00 	COMPLETED 01/08/2013		
NAME OF P	ROVIDER OR SUPPLIER D INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				practice does not recur: Staff will be retrained or Occazio's policy #2105 Abuse Neglect and Exploitation at the staff meeting on 1-30-13. Staff will retrained on the incident reporting guidelines at the investigation process. The importance of following the investigation process will be reviewed with RC. All staff members who to notify the administrator immediately will face disciplinaction per Occazio's policy regarding abuse, neglect and exploitation. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? The RC will monitor on daily basis when they are in the home. The Program Specialismonitor as they complete their audits.	e, eir ne and the fail ary re t a ne		
				5. What is the date by wh the systemic changes will be			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 31 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 15G225	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/08/2013			
NAME OF P	ROVIDER OR SUPPLIER	STREET 2 2234 Q	ADDRESS, CITY, STATE, ZIP CODE				
OCCAZIO	DINC	NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE			
			completed?				
			February 7 th , 2013				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 32 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	MBER: A. BUILDING		00	COMPLETED	
		15G225	B. WIN			01/08/2013	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER						
OCCAZIO) INC		2234 Q AVE NEW CASTLE, IN 47362				
				INL VV C	ASTEE, IN 47302		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0227	specific objectives client's needs, as comprehensive a paragraph (c)(3) of Based on observe interview for 3 of #3 and #4), the c Support Plans) factions' identified to meal preparations	ogram plan states the s necessary to meet the identified by the ssessment required by	W0	227	W 227 Individual Program Plate The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.		02/07/2013
	12/10/12 betwee following was of DCS (Direct Car frozen chicken p and placed the coto bake. At 4:30 box of frozen chicken took the tray of cadded more chicked in the oven bags of broccoli the freezer and p counter. At 4:45 large pot with was	cons at the group home on a 4 PM and 6:30 PM, the oserved: At 4:20 PM are Staff) #12 placed ieces onto a cookie sheet ookie sheet into the oven PM DCS #12 pulled a icken out of the freezer, whicken out of the oven, ken and placed the tray and cauliflower out of laced them on the PM DCS #12 filled a later, placed it on the the burner on. At 5:10			1. What corrective action will be accomplished? Staff will be retrained or ensuring active treatment and meal preparation process during their team meeting on 1-30-13 Programming will be purplace for Clients #1, #2, #3, and #4 to increase their independed with meal preparation. The ISP for Clients #1, #3, and #4 will be updated to include objectives to participate meal preparation. Client #3's behavior plan will be revised to include stealing food as a targeted behavior.	the ng t in nd nce #2, e in	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 33 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE S COMPLE 01/08/2	TED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIIV	STREET A 2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	PM DCS #12 was of the oven and of from the stove, putaking them to the clients #2, #3, and sitting at the table. During the time being prepared of standing at the control watching the standing the standing at the control watching the standing the stan	as taking the chicken out dipping up the vegetables placing them in bowls and the table. By 5:30 PM, and #4 were observed the for their evening meal. The evening meal was lient #1 was sitting or dining room table of prepare the meal. The observed in a wheel chair that to assist in the meal and the evening meal was in and out of the all times throughout the expression of the DCS were not observed #3 with the evening the was reviewed on the evening that the evening the was reviewed on the evening that the evening the was reviewed on the evening that the evening the was reviewed on the evening that the evening tha			2. How will we identify of residents having the potentit to be affected by the same deficient practice and what corrective action will be taked. All residents have the potential to be affected by the same deficient practice. The residents ISP's will reviewed and updated as the inneeds change. As the residents needs changed programming will be implemented. The residents behavior plans will be reviewed and updated as their needs change. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: The residents ISP's will reviewed and updated as their needs change. As the residents needs changed programming will be implemented. The residents behavior	en? I be ir I be	
I	bojectives to ass.	ist chefit #3 with mean			plans will be reviewed and		

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G225	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/08/2013		
NAME OF I	PROVIDER OR SUPPLIER O INC	STREET A 2234 Q	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
TAG	preparation. Client #4's record was reviewed on 12/11/12 at 1:35pm. Client #4's 9/12/12 ICAP indicated client #4 did not know how to mix and cook simple foods and required hand over hand assistance by staff. Client #4's 9/12/12 ISP failed to indicate any objectives to assist client #4 with meal preparation. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated clients #1, #3, and #4 required assistance with meal preparation and could not independently prepare a simple meal. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated clients #1, #3, and #4 could not independently prepare a meal. The RC indicated client #1, #3, and #4's ISP did not include any training objectives to assist the clients with meal preparation. 2. During observations at the group home on 12/10/12 between 4 PM and 6:30 PM, client #1's, #5's and #7's bedroom closet doors were locked. Client #3 was getting into client #4's closet at which time DCS #13 stated "That's not your stuff" and verbally prompted client #3 away from client #4's closet. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated clients #1, #2, #5,	TAG	updated as their needs change 4. How will the corrective action be monitored to ensu the deficient practice will no recur? The RC will monitor on daily basis when they are in thome. The Program Specialist monitor as they complete their audits. 5. What is the date by what the systemic changes will be completed? February 7 th, 2013	e DATE re t a ne t will r		
	12/10/12 at 6:40 PM indicated clients #1, #2, #5, #6 and #7 each had their own small refrigerators in their bedroom closets and each kept their closet					

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G225	B. WIN	G		01/08/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	KO VIDEK OK SOTTEIEN			2234 Q	AVE		
OCCAZIO	O INC			NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		#13 indicated client #3 would					
		inks that were left out and					
		he clients in the home had to					
		and drinks in their bedrooms to					
		stealing them. DCS #13					
		extra snacks and beverages					
		medication room per the					
		rder to secure them away from					
	client #3.						
	On 12/11/12 from 5	:55am until 8:35am,					
	observation and into	erview were conducted at the					
	group home. Client	ts #1, #2, #5, #6 and #7 each					
	had their own small	refrigerators in their bedroom					
	closets and each key	ot their closet doors locked.					
		5 stated "We keep them					
		and pop are in there. [Client					
	_	pop and we keep them locked					
	_	ent #3 opened and closed					
		where staff work on computer.					
		at #3 "was always looking for					
		asked what staff were to do					
		ed for food in desks or places DCS #6 stated "We just lock					
	all the extra food up	2					
	an the extra root up	so he can't get it.					
		5pm and on 12/12/12 at					
		record was reviewed. Client					
		did not identify client #3's food					
		an identified need. Client #3's					
		ual Support Plan) indicated					
	_	dian. Client #3's record					
		BSP (Behavior Support Plan)					
		behaviors of anxiety, agitation,					
	Physical Aggression	_					
		eating unhealthy snacks. not include his food stealing					
		's BSP included the behavior					
		ood items eating more than one					
		a 30 minute period of time					
		od someone else is eating."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 36 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225 A. BUILDING B. WING D. WING D		COM	1PLETED 08/2013		
NAME OF I	PROVIDER OR SUPPLIER		2234	EET ADDRESS, CITY, STATE, ZIP 4 Q AVE V CASTLE, IN 47362	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE
	with the QMRP/PD Professional/Progra indicated, client #3 other clients' food a QMRP/PD stated th personal refrigerato [client #3] taking th it." The QMRP/PD this behavior identic	m, an interview was conducted (Qualified Mental Retardation in Director). The QMRP/PD had the behavior of stealing ind pop then eating it. The ne other clients had locked its "because they did not want heir food and pop then eating its stated client #3 did not have fied "specifically" because "he it clients' personal foods if they				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 37 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		(X2) MULTIPLE C	OONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2013	
		15G225	B. WING		01/06/2013
NAME OF F	PROVIDER OR SUPPLIER O INC		2234 (ADDRESS, CITY, STATE, ZIP CODE AVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
W0242	for those clients of personal skills est independence (in toilet training, per hygiene, self-feed grooming, and coneeds), until it has the client is devel acquiring them. Based on record 4 of 4 sample client facility failed ISPs (Individual the clients' ident in regards to bath dressing for client brushing for client brushing for client brushing for client in the facility failed I. Client #1's resulting for client for client for client for client for facility failed I. Client #1's resulting for client for client for facility for for facility for formal for facility facility for facility facility for facility for facility facility facility for facility facility for facility	ogram plan must include, who lack them, training in sential for privacy and cluding, but not limited to, sonal hygiene, dental ting, bathing, dressing, mmunication of basic is been demonstrated that opmentally incapable of review and interview for ents (#1, #2, #3 and #4), It to ensure the clients' Support Plans) included iffied training objectives ming for clients #1 and #2, ints #1 and #3, tooth ints #1, #2, and #3 and int #4.	W0242	W 242 Individual Program The individual program plar include, for those clients whethem, training in personal sitessential for privacy and independence (including, but limited to, toilet training, per hygiene, dental hygiene, self-feeding, bathing, dressing grooming, and communicat basic needs), until it has be demonstrated that the client developmentally incapable acquiring them. 1. What corrective action will be accomplished? • Programming will be implemented for Client #1 of bathing, tooth brushing, and flossing. • Programming will be implemented for Client #2 of bathing, dressing and tooth	n must io lack kills ut not sonal ing, ion of en t is of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 38 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE	ETED	
15G225 B. WING - 01/08/2	2013	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 2234 Q AVE		
OCCAZIO INC NEW CASTLE, IN 47362		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATION ON ESCHELINITING INCOMMINION)	DATE	
Treesta) of Beechief 2012 indicated the		
staff were to monitor client #1's Programming will be		
toothbrushing twice a day. Client #1's implemented for Client #3 on		
ISP did not indicate any objectives to dressing, wearing clean clothing,		
assist client #1 with bathing and and tooth brushing.		
toothbrushing. Programming will be		
implemented for Client #4 on		
2. Client #2's record was reviewed on toileting independence.		
12/12/12 at 11 AM. Client #2's ICAP of		
8/28/12 indicated client #2 required staff The ISP's for Clients #1,		
assistance "with entire shower process, #2, #3, #4 will be updated to include the above mentioned		
toothbrushing and getting dressed."		
Client #2's ISP of 9/7/12 did not indicate		
any objectives to assist client #2 with		
bathing drassing and toothbrushing		
2. How will we identify other		
residents having the potential		
Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated to be affected by the same deficient practice and what		
and the address of the section of th		
chefit #1 required start prompting and		
supervision to bathe and brush his teeth. All residents have the		
DCS #13 indicated client #2 required potential to be affected by the		
physical and verbal assistance to bathe, same deficient practice.		
dress himself and to brush his teeth. The residents ISP's will be		
reviewed and updated as their		
Interview with the RC (Residential needs change.		
Coordinator) on 12/13/12 at 4 PM		
indicated clients #1 and #2 required staff As the residents needs		
supervision to bathe and brush their teeth changed programming will be implemented.		
and client #2 required staff assistance to		
dress himself. The RC indicated client . The residents behavior		
#1's ISP did not include any training plans will be reviewed and		
objectives to assist client #1 with bathing updated as their needs change.		
and toothbrushing and client #2's ISP did		
not include any training objectives to		

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUILDING B. WING	00 	COMPLETED 01/08/2013	
NAME OF P	ROVIDER OR SUPPLIER		2234 Q	ADDRESS, CITY, STATE, ZIP CODE 2 AVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG		rith bathing, dressing and	TAG	3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: The residents ISP's will reviewed and updated as their needs change. As the residents needs changed programming will be implemented. The residents behavior plans will be reviewed and updated as their needs change updated as their needs change. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? The RC will monitor on daily basis when they are in the home. The Program Specialist monitor as they complete their audits. 5. What is the date by whith the systemic changes will be completed? February 7 th , 2013	be for the state of the state o
			1	1	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 40 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G225	B. WIN			01/08/	2013
			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
OCCAZIO	O INIC			2234 Q			
UCCAZI	JING			NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3. On 12/11/12	at 7:15am, client #3 got	W02	242			02/07/2013
	out of bed, walk	ed to the medication			W 242 Individual Program Pla	an	
		ed to the kitchen wearing					
	•	:55am, client #3 wore the			The individual program plan m		
		·			include, for those clients who I		
		e had slept in and			them, training in personal skills	5	
	1 ^ ^	e for work. At 7:55am,			essential for privacy and	not	
	DCS (Direct Car	re Staff) #2 was asked if			independence (including, but r limited to, toilet training, perso		
	that was the sam	e tee shirt. At 7:55am,			hygiene, dental hygiene,	ııaı	
	DCS #2 prompte	ed client #3 to change his			self-feeding, bathing, dressing	•	
	tee shirt which h	e had slept in and was			grooming, and communication		
		m, the House Manager			basic needs), until it has been		
					demonstrated that the client is		
		nt #3 wears the same			developmentally incapable of		
		nes" to bed then will wear			acquiring them.		
	to workshop "if	we don't watch it."					
	Client #3's recor	d was reviewed on			1. What corrective action		
	12/11/12 at 2:15	pm and on 12/12/12 at			will be accomplished?		
		#3's 8/28/12 ICAP			wiii be decemplished:		
		#3 "does fairly well" to			· Programming will be		
					implemented for Client #1 on		
	1	did not identify changing			bathing, tooth brushing, and		
		tee shirt. Client #3's			flossing.		
	10/19/12 Dental	assessment indicated his					
	teeth were clean	ed under Anesthesia.			· Programming will be		
	Client #3's ICAI	e did not assess			implemented for Client #2 on		
	toothbrushing. (Client #3's 4/3/12 ISP did			bathing, dressing and tooth brushing.		
		objectives to assist client			brushing.		
	_ _	and toothbrushing.			· Programming will be		
		, and toothorushing.			implemented for Client #3 on		
					dressing, wearing clean clothing	ng,	
		he RC on 12/13/12 at 4			and tooth brushing.		
	PM indicated cli	ent #3's ISP did not					
	include any trair	ning objectives to assist			· Programming will be		
	client #3 with dr	ressing and toothbrushing.			implemented for Client #4 on		
		5 6			toileting independence.		
	4 Client #4's re	cord was reviewed on			· The ISP's for Clients #1		
	¬. Chent #¬ 5 16	cora was reviewed on	1			,	ĺ

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G225	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 01/08/2013
NAME OF	PROVIDER OR SUPPLIER O INC	2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	12/11/12 at 1:35pm. Client #4's 10/18/12 Physician Orders indicated he was prescribed Oxybutynin since 4/2/2009 as a "General Medication" for incontinence. Client #4's 9/12/12 ICAP indicated client #4 "does very well (sic) Uses the toilet at regular times when placed on the toilet or when taken to the bathroom." Client #4's 9/12/12 ISP did not indicate any objectives to assist client #4 with toileting. Interview with the RC (Residential Coordinator) on 12/13/12 at 4 PM indicated client #4's ISP did not include any training objectives to assist client #4 with toileting. 9-3-4(a)		#2, #3, #4 will be updated to include the above mentioned objectives. 2. How will we identify off residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents have the potential to be affected by the same deficient practice. The residents ISP's will reviewed and updated as their needs change. As the residents needs changed programming will be implemented. The residents behavior plans will be reviewed and updated and updated as their needs change. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: The residents ISP's will reviewed and updated as their needs change. As the residents needs changed programming will be	ner al en? be r be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 42 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G225	B. WING		01/08/2013
NAME OF F	PROVIDER OR SUPPLIE	IR .		ADDRESS, CITY, STATE, ZIP CODE	
OCCAZIO) INC		2234 C	Q AVE CASTLE, IN 47362	
				DAGILE, IN 41302	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
	-	<u> </u>		implemented.	
				 The residents behavior plans will be reviewed and 	
				updated as their needs chang	ge.
				4. How will the corrective	,
				action be monitored to ensu	
				the deficient practice will no	ot
				recur?	
				· The RC will monitor on	а
				daily basis when they are in t	he
				home.	
				· The Program Specialis	t will
				monitor as they complete the	
				audits.	
				5. What is the date by wh	
				the systemic changes will b completed?	e
				- Completed :	
				February 7 th , 2013	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 43 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	15G225		LDING	00	01/08/	
		100220	B. WING			01/00/	2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	O INC			2234 Q NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID PROVI		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0304	483.450(d)(5) PHYSICAL REST Restraints must b		W0		W 304 Physical Restraints Restraints must be designed a used so as not to cause physicinjury to the client. 1. What corrective action will be accomplished? Staff will be retrained or	cal	02/07/2013
					the HWC restraint on 1-30-13 during their team meeting. The IDT will meet on 1-30-13 to discuss the continu need for restraint in Client #6's behavior plan and explore idea on how injuries can be preven	led S as	
					2. How will we identify oth residents having the potentia to be affected by the same deficient practice and what corrective action will be take All residents have the potential to be affected by the same deficient practice. Staff will be retrained or the HWC restraint on 1-30-13 during their team meeting.	al n?	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 44 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00 	COMPLETED 01/08/2013
NAME OF P	ROVIDER OR SUPPLIEF		2234 C	ADDRESS, CITY, STATE, ZIP CODE Q AVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				 As behavior concerns a the IDT will meet to address the needs. 	
				3. What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur:	nic
				 Staff will be retrained of the HWC restraint on 1-30-13 during their team meeting. 	•
				 As behavior concerns a the IDT will meet to address the needs. 	
				4. How will the corrective action be monitored to ensu the deficient practice will no recur?	re
				The RC will monitor on daily basis when they are in the home.	ne
				The Program Specialist monitor as they complete their audits.	
				5. What is the date by whi the systemic changes will be completed?	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 45 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		15G225	B. WIN			01/08/	2013
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	O INC			2234 Q NEW C	AVE ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					February 7 th , 2013		
	Događ on rogard	ravious and intervious the					
		review and interview, the protect 1 of 1 client who					
	1	•					
		estrained (client #6) from					
	injury due to the	restraint.					
	Findings include						
	Tilldings include	··					
	The facility's rec	ords were reviewed on					
	1	5 AM. The facility's					
		of Developmental					
	`	ices) report of 3/14/12					
		#6 became upset, began					
		and pulling staff's hair.					
	1						
	-	laced in the standing					
		as taught by our Handle					
	with Care progra	ım.					
	Review of the "O	General Event Report" of					
		d the DCS (Direct Care					
		client #6 to prevent him					
	, ,	things." The report					
	1	#6 obtained a bruise					
		ne size of a quarter on					
		The report indicated					
		ured due to the restraint.					
	-	ated the RC (Residential					
		riewed the report and					
	· ·	aff had some difficulty					
		ent #6) in restraint and					
	had to reapply."	one not in restraint and					
	nad to reappry.						
	Interview with the	ne RC on 12/13/12 at 4					
	Interview with th	10 10 011 12/13/12 at T					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 46 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G225	(X2) MULTIPLE CO A. BUILDING B. WING	00	_	
NAME OF F	PROVIDER OR SUPPLIER	2234 Q	ADDRESS, CITY, STATE, ZIP 2 AVE CASTLE, IN 47362	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	PM indicated client #6's injury was due to the restraint.				
	9-3-5(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 47 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G225	B. WING 01/08/2013			2013	
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2234 Q			
OCCAZIO) INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0316	483.450(e)(4)(ii)						
	DRUG USAGE	ontrol of inappropriate					
		gradually withdrawn at					
	least annually.	gradan, minaram at					
	Based on record	review and interview, for	W0	316			02/07/2013
		lients (clients #1 and #3)			W 316 Drug Usage		
	•	ychotropic medications,					
		to evaluate client #1 and			Drugs used for control of		
	•	annual decrease or			inappropriate behavior must be gradually withdrawn at least	e	
	contraindication				annually.		
	medication.	or psychotropic			arridany.		
	medication.						
	Pluding to 1 4.						
	Findings include	:			1. What corrective action		
					will be accomplished?		
		cord was reviewed on			Client #1's next psychia	trist	
		M. Client #1's ISP			appointment is scheduled for		
	(Individual Supp	ort Plan) of 8/29/12			3-26-13. At that appointment the		
	included a PSP (Psychotropic Service			need for a possible reduction v		
	Plan) dated 11/3/	12 which indicated client			be discussed with the physicia		
	#1 had targeted b	behaviors of anxiety,			the client has met the criteria f reduction.	or	
	agitation, attention	on seeking, obsessive			reduction.		
		compliance, verbal			· Client #3's next		
	•	elf-injurious behaviors.			psychiatrist appointment is		
		ndicated client #1 was			scheduled for 4-1-13. At that		
	-	l to address the client's			appointment the need for a		
		llsive behaviors. Client			possible reduction will be discussed with the physician if	the	
					client has met the criteria for	uic	
		e medication reviews of			reduction.		
		, 3/26/12 and 9/24/12					
		tinued use of Luvox 100			The RC will be retrained		
		a day and Doxepin 10			how to write psych consults to		
		for depression and			provide to the psychiatrist at the scheduled appointments so the		
	anxiety. The med	dication reviews			an informed decision can be	۵۱ ا	
	indicated:				made about the medications a	t I	
	9/24/12 - "Contin	nues to do well." "No			that time.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 48 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED
		15G225	B. WIN			01/08/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		2234 Q		
OCCAZIO	O INC				ASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	request for med	changes."				
	3/26/12 - "Conti	nues to do well with				
	stable behaviors	."			2 How will we identify oth	
	9/27/11 - "Conti	nues to do well." "No			2. How will we identify oth residents having the potential	
	problems."				to be affected by the same	"
		nues to do well." No			deficient practice and what	
	medication chan				corrective action will be take	n?
		_				
		d and psychotropic			· All residents have the	
		ews did not indicate a			potential to be affected by the	
	_	aindication of change of			same deficient practice.	
	client #1's psych	otropic medication.			The RC will be retrained	d on
	Client #1's recor	d did not indicate the last			how to write psych consults to	
	psychotropic me	edication change or			provide to the psychiatrist at the	
	contraindication	. No behavior data was			scheduled appointments so th	at
	provided for rev	iew.			an informed decision can be	
	F				made about the medications a	t
	Interview with t	he RC (Residential			that time.	
		12/13/12 at 3 PM stated			The IDT will discuss the	
	1	t had a medication			residents continued need for	
		previous year "that I			psychotropic medications prior	r to
					their scheduled psychiatric	
		RC stated since client #1			appointment.	
	_	idepressants," client #1				
		be considered for an				
	annual medication	on reduction.			3. What measures will be	
					put into place or what system	nic
	2. A review of o	client #3's record was			changes will be made to	
	completed on 12	2/11/12 at 2:15pm and on			ensure that the deficient	
	12/12/12 at 1:40pm. Client #3's 4/3/12				practice does not recur:	
	Individual Supp	ort Plan (ISP) and 4/2012			The RC will be retrained	d on
		Support Plan) indicated he			how to write psych consults to	
	`	aviors of agitation,			provide to the psychiatrist at the	
		sical aggression, and			scheduled appointments so th	
		ting/unhealthy food.			an informed decision can be	
		12 and 4/2/12 Psychiatric			made about the medications a	t
	CHCIII #3 8 10/1/	12 and 4/2/12 1 Sychiatic			that time.	

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMPLETED
	15G225	B. WING		01/08/2013
NAME OF I	PROVIDER OR SUPPLIER O INC	2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	medication reviews indicated the use of Risperdal 0.5mg (milligrams) for anxiety and agitation, and Paxil 40mg for anxiety and agitation. Client #3's Psychological Reviews indicated client #3's behaviors and "no" changes. No behavior rates were available for review. Client #3's		The IDT will discuss the residents continued need for psychotropic medications prio their scheduled psychiatric appointment.	
	10/1/12 Psychological Review indicated "continues to do well, return 6 months." Client #3's 4/2/12 Psychological Review indicated "continues to do very well, return 6 months." Client #3's 10/22/12		4. How will the corrective action be monitored to ensu the deficient practice will no recur?	re t
	"Clinician Report" indicated a goal "To decrease incidents of agitation, anxiety, rumination, physical aggression,		The RC will monitor on daily basis when they are in the home.	ne
	wandering away from staff while in the community, and inappropriate food items." Client #3's clinician report		The Program Specialist monitor as they complete thei audits.	
	indicated "Criteria for Completion: When data reflects a stabilization of symptoms: reduce physical aggression by 50% within 6 months and by 100% within 1 year, Reduce anxiety/agitation/rumination by		5. What is the date by wh the systemic changes will be completed?	
	50% within 6 months and 100% within 1 year, the IDT (Interdisciplinary Team) will refer to the prescribing physician for a consideration of a reduction in		February 7 th , 2013	
	medication or alternate medication." Client #3's record and psychotropic medication reviews did not indicate a			
	change or contraindication of change of client #3's psychotropic medication. Client #3's record did not indicate the last psychotropic medication change or			

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILI DIDIC	00	COMP	LETED
		15G225	A. BUILDING		01/08	3/2013
			B. WING	Γ ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			E	
000471	0.1110			Q AVE		
OCCAZIO	OINC		NEW	CASTLE, IN 47362		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	LD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	TOT TUTTE	DATE
	contraindication	l .				
	An interview wi	ith the Program				
		led Mental Retardation				
	`	D/QMRP) and Residential				
	`	C) was conducted on				
	`	30am. The PD/QMRP				
		ditional information was				
		view to determine if client				
		ic medication was				
	evaluated for an	annual decrease or if a				
	decrease was co	ntraindicated. The				
	PD/QMRP state	ed client #3's record				
	,	#3 was "stable" for				
	behaviors.					
	ochaviois.					
	0.2.5(-)					
	9-3-5(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 51 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15G225	A. BUILDING		00	01/08/	
		150225	B. WING			01/06/	2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO) INC			2234 Q NEW C	CASTLE, IN 47362		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	DECLIDED IN AN OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0331	483.460(c) NURSING SERV The facility must p		W0		W 331 Nursing Services The facility must provide client with nursing services in accordance with their needs. 1. What corrective action will be accomplished? Regular meal observation will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. Staff will be retrained or Client #1, #2, #3, #4, #5, #6, at #7's dining plans, how to prove appropriate food substitutions the importance of following the menu at their staff meeting on 1-30-13. Client #1, #2, #3, #4, #5, #6, and #7 will be placed on programming to follow their dients will be available within the home for staff to follow their dients with the home for staff to follow within the home for staff to follow their dients within the h	ons n and ide and e	02/07/2013
					· The dietician completed	I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 52 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00	COMPLETED 01/08/2013		
NAME OF P	ROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				her quarterly evaluations for the home on 1-24-13. Upon receive her recommendations, the IDT will review and implement the recommendations accordingly	ving		
				Client #7 attended week diabetic education classes. His last class was scheduled for 1-23-13.	-		
				The MAR's for clients # #2 and #7 to ensure that the correct dietary orders were in place.	1,		
				Staff will be trained on to importance of documentation regarding health care needs (in blood sugars, bowel movement blood pressures, weight, etc.), how to complete appropriate health care reporting forms accurately, reasons to contact RC and reporting to the RC/Nut per MAR and risk plan directive during their staff meeting on 1-30-13.	.e. nts, the urse		
				 Client #1 will have his Plab drawn before 2-7-13. The risk plans for Client #2 and #7 will be reviewed and updated as necessary. The importance of following the physician's order will be reviewed with the staff the RC on 1-30-13 during their team meeting. 	#1, d 's and		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 53 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING 00 COM		COMPLETED 01/08/2013		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
OCCAZIO) INC		2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION DATE It he ns, ups		
				corrective action will be take All residents have the	n?		
				potential to be affected by the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 54 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

A. BUILDING B. WING	COMPLETED - 01/08/2013		
STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362			
ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION		
same deficient practice. Regular meal observilled by the and/or the DSA for the interest that the menu is followed and that staff and encouraging the resident follow their prescribed deplans. Staff will be retrained the importance of follow menu at their staff meet 1-30-13. All of the menus in for the clients will be available to the importance of document in the importance of t	servations e RC nome to being are ints to lining ined on is, #6, and io provide utions and ing the ing on prescribed ailable f to follow. ed on the tation eeds (i.e. evements, is, etc.), oriate rms contact the RC/Nurse directives g on of s orders e staff and		
	STREET ADDRESS, CITY, STATE, ZIP CO 2234 Q AVE NEW CASTLE, IN 47362 ID PREFIX TAG PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY) Same deficient practice. Regular meal obs will be completed by the and/or the DSA for the R ensure that the menu is followed and that staff a encouraging the resider follow their prescribed of plans. Staff will be retrait Client #1, #2, #3, #4, #5 #7's dining plans, how t appropriate food substite the importance of follow menu at their staff meet 1-30-13. All of the menus is for the clients will be avoid within the home for staff Staff will be trained importance of documen regarding health care no blood sugars, bowel mod blood pressures, weight how to complete approp health care reporting for accurately, reasons to co RC and reporting to the per MAR and risk plan of during their staff meetin 1-30-13. The importance of following the physician's will be reviewed with the the RC on 1-30-13 during		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 55 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING 00 COM		COMPLETED 01/08/2013
NAME OF P	ROVIDER OR SUPPLIER		2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				The nurse will documer any reported concerns about t clients in the Health Notes or GER's when appropriate.	
				The risk plans will be reviewed for all residents and updated as their needs change.	e.
				The MAR's for all reside will be reviewed and updated their needs change.	
				The med charts will be reviewed for all residents to ensure doctor recommendatio required appointments/follow and labs are completed as ordered.	
				3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur:	nic
				Regular meal observation will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans.	
				Staff will be retrained or Client #1, #2, #3, #4, #5, #6, a #7's dining plans, how to prov appropriate food substitutions the importance of following the menu at their staff meeting on 1-30-13.	and and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 56 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	<u>00</u>	COMPLETED 01/08/2013
NAME OF P	ROVIDER OR SUPPLIEF		2234 C	ADDRESS, CITY, STATE, ZIP CODE Q AVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	All of the menus prescrifor the clients will be available within the home for staff to foll Staff will be trained on to importance of documentation regarding health care needs (in blood sugars, bowel movement blood pressures, weight, etc.), how to complete appropriate health care reporting forms accurately, reasons to contact RC and reporting to the RC/Nuper MAR and risk plan directive during their staff meeting on 1-30-13. The importance of following the physician's order will be reviewed with the staff the RC on 1-30-13 during their team meeting. The nurse will document any reported concerns about the clients in the Health Notes or GER's when appropriate. The risk plans will be reviewed for all residents and updated as their needs change. The MAR's for all residents to ensure doctor recommendation.	ibed dow. the die. i.e. ints, diethe urse ves rs and r the the e. ents as
				required appointments/follow and labs are completed as	uµs

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 57 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		15G225	B. WIN			01/08/2013
(E. O.D. P.					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIER	<		2234 Q	AVE	
OCCAZIO					ASTLE, IN 47362	,
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	REGULATORT ON	CESC IDENTIFY ING INFORMATION)		TAG	ordered.	DATE
					ordered.	
					4. How will the corrective	
					action be monitored to ensu	
					the deficient practice will no recur?	·
					· The RC will monitor on	
					daily basis when they are in th	ne
					home.	
					The nurse will monitor a	as
					concerns are reported to her,	
					during her regular audits and	
					through review of health care	
					reports.	
					The Program Specialist	: will
					monitor as they complete their	
					audits.	
					5. What is the date by whi	ich
					the systemic changes will be	•
					completed?	
					February 7 th , 2013	
	D 1 1					
		vation, record review and				
		of 4 sampled clients (#1				
	· ·	lditional client (#7), the				
		services failed to ensure:				
	•	are plans that included				
	parameters of lo	w and high blood sugar				
	results and when	the staff was to notify				
	the nurse were d	-				
		address client #1's and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 58 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
111,12,12,111	or condition.	15G225		LDING		01/08/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2		2234 Q			
OCCAZI	O INC			•	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		ealth care needs in		TAG	,		DATE
		tes; the DCS followed the					
	1 -	ng blood sugars; the DCS					
	_	taking client #2's and #7's					
	<u>-</u>	S notified nursing of					
	_	s, the DCS documented					
		cal information as					
		loctor and the DCS					
	followed the fac						
		Ž					
	Findings include	2:					
	During observat	ions at the group home on					
	12/10/12 betwee	en 4 PM and 6:30 PM,					
	clients #1, #2, #3	3, #4, #5, #6 and #7 were					
	eating their even	ing meal. The evening					
	meal consisted o	of oven fried chicken,					
		wer mix, mashed					
	_	it cocktail with water and					
		. Client #7 was took					
		of everything. While the					
		ent #7's housemates with					
		es, client #7 began picking					
	_	mbs of oven fried chicken					
	_	of chicken and eating					
		then began pulling the					
		pieces of chicken he had					
		ate and began eating that.					
	_	a serving of broccoli and					
		is plate but did not eat it.					
		ryone was finished eating					
	_	who remained at the table					
		eat. DCS #12 began					
	clearing the table	e of the remaining food.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 59 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE (COMPL	
NAME OF PROVIDER OR SUPPLIER CCCAZIO INC (M) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG DCS #12 asked client #7 if he wanted the rest of the mashed potatoes and put the remaining potatoes onto client #7s plate. While doing so DCS #12 stated, "You shouldn't eat so much because it will raise your blood sugar." Throughout the evening meal the DCS did not prompt client #7 on appropriate serving sizes. Chents #1, #2, #3, #4, #5, #6 and #7 were not offered bread, margarine or milk during this observation or an equal substitution. The DCS did not offer client #1 a substitution for the broccoli/cauliflower mix he did not eat. During observations at the group home on 12/11/12 from 5:55 am until 8:35 am, client #7 ate a banana, milk, juice, cold cereal, toast, and two bags of microwave popeorn. At 7:50 am client #7 ate a bag of popeorn in the kitchen while talking with the RC (Residential Coordinator). Then at 7:55 am, DCS #5 assisted client #7 to pack his lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From	ANDILAN	OF CORRECTION				00		
OCCAZIO INC OCM/ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG OCS #12 asked client #7 if he wanted the rest of the mashed potatoes and put the remaining potatoes onto client #7 splate. While doing so DCS #12 asked client #7 if he wanted the remaining potatoes onto client #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 splate. While doing so DCS #12 asked drient #7 were not offered bread, margarine or milk during this observation or an equal substitution for the broccoli/cauliflower mix he did not eat. During observations at the group home on 12/11/12 from 5:55 am until 8:35 am, client #7 ate a banana, milk, juice, cold cereal, toast, and two bags of microwave poporom. A1 7:50 am client #7 ate a bag of poporn in the kitchen while talking with the RC (Residential Coordinator). Then at 7:55 am, DCS #5 assisted client #7 to pack his lunch box with three bags of microwave poporom inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From			100223	B. WIN			01/00/	2010
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Clients #1, #2, #3, #4, #5, #6 and #7 were not offered bread, margarine or milk during this observation or an equal substitution. The DCS did not offer client #1 a substitution for the broccoli/cauliflower mix he did not eat. During observations at the group home on 12/11/12 from 5:55 am until 8:35 am, client #7 ate a banana, milk, juice, cold cereal, toast, and two bags of microwave popcorn. At 7:50 am client #7 ate a bag of popcorn in the kitchen while talking with the RC (Residential Coordinator). Then at 7:55 am, DCS #5 assisted client #7 to pack his lunch box with three bags of microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From			• •					
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popcorn. At 7:50 am client #7 ate a bag of popcorn in the kitchen while talking with the RC (Residential Coordinator). Then at 7:55 am, DCS #5 assisted client #7 to pack his lunch box with three bags of microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		client #7 ate a ba	nana, milk, juice, cold					
popcorn in the kitchen while talking with the RC (Residential Coordinator). Then at 7:55 am, DCS #5 assisted client #7 to pack his lunch box with three bags of microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		cereal, toast, and	two bags of microwave					
the RC (Residential Coordinator). Then at 7:55 am, DCS #5 assisted client #7 to pack his lunch box with three bags of microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		popcorn. At 7:50	am client #7 ate a bag of					
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pack his lunch box with three bags of microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		the RC (Residen	tial Coordinator). Then at					
microwave popcorn inside. DCS #5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		7:55 am, DCS #:	5 assisted client #7 to					
indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		pack his lunch be	ox with three bags of					
and a second lunch box was brought to the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		microwave popc	orn inside. DCS #5					
the workshop at noon daily for his consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		indicated client #	7 took this lunch box					
Consumption after his noon blood sugar. On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		and a second lun	ch box was brought to					
On 12/11/12 from 10:35am until 12:20pm, observations and interviews were completed at the workshop. From		the workshop at	noon daily for his					
12:20pm, observations and interviews were completed at the workshop. From		consumption after	er his noon blood sugar.					
were completed at the workshop. From		On 12/11/12 from	m 10:35am until					
were completed at the workshop. From		12:20pm, observ	rations and interviews					
		_						
		_	_					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 60 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	OLTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
MOLLAN	OI COMMECTION	15G225		LDING		01/08/	
		100220	B. WIN		DDDEGG GITY OT TE ZIP CORE	0 1/00/	
NAME OF F	PROVIDER OR SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILICI I		DATE
		ne workshop area, the com one classroom to the					
		From 10:35am until					
		fixed his own bag of					
		orn and consumed it					
	while he walked						
		t #7 walked into and out					
	of offices in the						
		e lobby area. During the					
	-	55am until 12noon client					
	•	tored by the workshop					
		im to activity or monitor					
		on within the workshop.					
		ent #7 stated "I eat about 4					
	· ·	corn when I'm here a					
		n, client #7's Workshop					
	1	S) indicated client #7 did					
	• `	f microwave popcorn a					
	_	ended workshop. Client					
		or the facility staff to					
	come and check	client #7's blood sugar.					
	At 12:10pm, clie	ent #7 had his blood sugar					
	check and it was	338.					
	The facility's rec	ords were reviewed on					
	12/11/12 at 11:1	5 AM. The facility's					
	General Event R	eport of 5/24/12					
	indicated while t	he DCS was preparing					
	client #7's insuli	n, client #7 grabbed the					
	needle from the	DCS's hands, rolled the					
	Humalog up to 6	0 units and injected					
	himself with the	60 units of Humalog					
	insulin. The repo	ort indicated the DCS					
	called the RC (R	esidential Coordinator),					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 61 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUII		00	COMPL	ETED
		15G225	B. WIN	G		01/08/	2013
NAME OF PROVIDER OF	R SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362		
PREFIX (EACH TAG REGUL	DEFICIEN ATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) E nurse and the nurse told		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
the RC t	o call the	e doctor and the doctor to monitor the client's					
12/10/12 provided group he 1800 KC 10/7/09. meal on have:3 oun1/2 cu of cooke1 cup1 slice margarii1/2 cu1 cup1 cup8 to 1 Review of Decer indicated for meat broccoli the rease "guys ch include"	2 at 6 PM d for revious was CAL(kild The mental 12/10/12 ces of managed corn of green e of breat the of water of water of skim 2 ounces of the Formber 201d the stand loaf and caulifloton for the	beans d with 1 teaspoon of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 62 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUILDING B. WING			COMPLETED 01/08/2013		
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2234 Q			
OCCAZIO	O INC			NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710		d was reviewed on		1710			DATE
		M. The client's record					
		ent had a diagnosis of, but					
	not limited to, In	•					
	Diabetes.	1					
	Client #1's 8/2	9/12 ISP (Individual					
	Support Plan) ind	,					
		f to make sure healthy					
	choices are avail	able for him to help him					
	maintain his bloc	od sugar levels." Client					
	#1's December N	MAR (Medication					
	Administration R	Record) indicated the					
	client was on a "	Renal Calorie Diet" and					
	could have secon	nd helpings of					
	non-starchy vege	etables and protein. The					
		ated client #1 was on a					
	_	at no concentrated					
		e client's quarterly					
		of 2/6/12 indicated the					
		ered the 1800 KCAL					
		1 to lower his potassium					
		eian indicated she had					
	1 *	00 KCAL, low potassium					
		lient #1 with his renal					
		nutrition review of					
		the client's diet was not					
		s orders as previously					
	_	e client may not be et as recommended. The					
		iled to indicate nursing					
		ressed the change of diet					
	by the dietician a	_					
	recommendation						
		. 12 MARs indicated client					
		- 1.11 III III III III III III III III II					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 63 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225			LDING	NSTRUCTION 00	(X3) DATE COMPI 01/08	ETED	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	(an oral anti-dial as Humalog Insu 12 units every da The MAR inchave his blood sure and if the client's 100 or over 250, the RC. The MA to have his BP (I weekly and to be Client #1's 12/1/12 through #1's blood sugar December 1, 2, 3 indicated the clie on 12/8/12. The was not fasting f sugars taken and DCS failed to do fasting or not Client #1's 11/1/12 through #1's blood sugar November 5, 6, and 29. The republood sugar was 11/30/12. The rewas not fasting f sugars taken in N Client #1's reclast PSA (Prosta	dicated client #1 was to agar taken twice a day a blood sugar was below the DCS were to notify. R indicated client #1 was blood pressure) taken weighed weekly. Heath Care Report for 12/12/12 indicated client was below 100 on 8, 6, 8 and 10. The report ent's blood sugar was 251 report indicated the client for 19 of the 21 blood for 2 of the results, the boument if the client was below 100 on 7, 12, 14, 15, 20, 22, 28 ort indicated the client for any of the blood solvember. For any of the blood solvember. For dindicated the client's the Specific Antigen), a reprostate cancer, was last					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 64 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/08/	ETED		
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	
	facility nurse was #1's blood sugar #1's record did nof care in regard issues, when the nurse and of what not indicate a nu #1's medical data. November and I. Client #2's recort 12/12/12 at 11 A assessment of 5/weighed 111 porweight range of assessment indicates assessment indicates. "some concern was Appears to have between Feb (Fethen lost 16# bet CIB (Carnation nutritional supplication of the concern was assessed to TID in order to maint dietician indicates encourage client and to substitute Client #2's recorservices had addiconcerns.	cord did not indicate the s notified when client s were elevated. Client ot indicate a nursing plan is to client #1's medical staff are to notify the at. Client #1's record did rese had reviewed client a for September, October, December 2012. In the standard staff are to notify the at. Client #1's record did rese had reviewed client a for September, October, December 2012. In the staff are to notify the at. Client #2's nutritional with an average and with an average and with an average and the dietician had with gain and then loss? In the staff and the staff and the staff and and the staff and t						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 65 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

l l		00	COMPLETED
15G225	A. BUILDING B. WING		01/08/2013
NAME OF PROVIDER OR SUPPLIED		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	2234 Q		
OCCAZIO INC	NEW C	ASTLE, IN 47362	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMAT		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
12/12/12 at 2 PM. Client #7's record	ION) IAO		DATE
indicated diagnose of, but not limited to			
Type II Insulin Dependent Diabetic,	,		
Diabetic Neuropathy (damage to nerves	in		
the body that occurs due to high blood			
sugar levels from diabetes), Obesity,			
Chronic Diastolic Heart Failure, Epileps			
BPH (enlarged prostrate), Sleep Apnea.			
Client #7's ISP of 4/3/12 indicated the	:_		
client was "quite obese" and was diabet	ic		
"with increasing problems with			
controlling his high blood sugars."			
Client #7's quarterly physician review			
for 2012 indicated client #7 was to have			
his blood sugar taken TID (3 times a da	y)		
"before meals."			
Client #7's 2012 MARs indicated clie	ent		
#7 was taking Glipizide 10 milligrams			
and Metformin 2000 milligrams (oral			
anti-diabetic drugs) a day as well as			
Lantus Insulin 60 units and Humalog			
Insulin 16 units three times a day with			
extra coverage of Humalog for blood			
sugars above 160 for his diabetes. The			
MAR indicated client #7 was to have hi	S		
blood sugar taken "3 times daily before			
meals" and if the client's blood sugar wa			
below 100 or over 250, the DCS were to			
notify the RC. The MARs indicated clie	ent		
#7 was to have his BP (blood pressure)			
taken daily and if the client's BP was les	SS		
than 100/60 or greater than 140/90, the			
DCS were to notify the RC. The MAR			
indicated the client was to be weighed			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 66 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/08/	ETED		
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE	
	12/1/12 through #7's blood sugar of 20 times taken were over 300. To client was not hat taken 3 times a conference of the 36 times his blood sugar to indicated the client of the blood sugar results, the DCS client was fasting indicated on 12/9 156/102. Client #7's Here 11/1/12 through client was not hat taken 3 times a conference over 400 times blood sugars the DCS did test 34 were over 400. To client was not fasting or not. The 11/15/12 client #7 to the sugar tests and for the 11/15/12 client #7 to the 11/15/12 client #7 t	ralth Care Report for 12/12/12 indicated client is were over 160 - 19 out in, 14 were over 200 and 2. The report indicated the aving his blood sugar day as the physician DCS had not documented its the client was to have ested. The report ent was not fasting for 7 far tests and for 7 of the failed to document if the gor not. The report ent #7's BP was ralth Care Report for 11/30/12 indicated the aving his blood sugar day as the physician DCS had not documented est the client was to have tested. Of the 37 times client #7's blood sugars, 0. Of those 34 tests, 15 is were over 300 and 6. The report indicated the sting for 14 of the blood for 10 of the results, the ocument if the client was the report indicated on far's BP was 141/103. The client #7's weight was						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 67 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		15G225	B. WIN			01/08/	2013
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	O INC			2234 Q NEW C	AVE ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	301 pounds for 3	weeks in a row without					
	change.						
		ealth Care Report for					
	_	10/31/12 indicated the					
		ving his blood sugar					
		lay as the physician					
		DCS had not documented					
	31 of the 93 time	es the client was to have					
		tested. Of the 31 times					
	the DCS did test	client #7's blood sugars,					
	51 were over 160	0. Of those 34 tests, 35					
	were over 200, 1	3 were over 300. The					
	report indicated	the client was not fasting					
		od sugar tests and for 30					
	of the results, the	e DCS failed to document					
	if the client was	fasting or not. The report					
	indicated client #	7's weight was 290					
	pounds for 5 week	eks in a row without					
	change.						
	Client #7's He	ealth Care Report for					
		/30/12 indicated the					
	client was not ha	wing his blood sugar					
		lay as the physician					
	-	DCS had not documented					
		es the client was to have					
	his blood sugars	tested. Of the 67 times					
		client #7's blood sugars,					
	63 were over 160	0. Of those 63 tests, 39					
	were over 200, 1	2 were over 300 and 2					
	were over 400. T	The report indicated the					
	client was not fa	sting for 15 of the blood					
	sugar tests and fo	or 46 of the results, the					
		ocument if the client was					
	fasting or not. The	he report indicated on					
	•		•				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 68 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE (COMPL		
ANDILAN	OI COMMENTON	15G225		LDING		01/08/	
		100220	B. WIN		DDDEGG CITY OT TE ZID CORE	0 1/00/	
NAME OF F	PROVIDER OR SUPPLIER			2234 Q	AVE		
OCCAZIO	O INC			•	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		"s BP was 141/103. The		TAG	Dia relation,		DATE
		client #7's weight was					
	_	weeks in a row without					
		ort indicated the RC did					
		eptember data until					
		port indicated the facility					
		riew the September data					
		The nurse indicated					
		of missing BM (bowel					
		king/skin assessments, but					
	no reported issue						
		ord did not indicate the					
		s notified when client					
	1	s and blood pressures					
		lient #7's record did not					
	indicate a nursin	g plan of care in regards					
		dical issues that included					
	when the staff ar	e to notify the nurse and					
	of what.						
	Interview with c	lient #1 on 12/10/12 at					
		ed he did not eat his					
		wer mixture because he					
	didn't like it. Wh	en asked if the DCS had					
		hing in place of the					
		wer mixture, the client					
		e client indicated he					
		d to have something else					
	-	egetables that were					
	offered.						
		000 1114 1 1110					
		OCS #14 and #12 on					
		I indicated DCS #12 did					
	not know which	menu he was to be					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 69 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE (COMPL		
ANDILAN	OI CORRECTION	15G225		LDING		01/08/	
		.00220	B. WIN		DDDECC CITY CTATE IN CORE	0 1/00/	
NAME OF F	PROVIDER OR SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		preparation of the		1710	<u> </u>		DATE
	_	CS #14 indicated because					
	_	r had brought food into					
	1	revious meal and due to					
	-	ne home and the need to					
	go shopping, the	Monday evening menu					
		ated for a Sunday lunch.					
	DCS #12 indicat	red the Fall/Winter 1800					
	KCAL menu wa	s the only menu in the					
	home and the on	e that was followed for					
	clients #1, #2, #3	3, #4, #5, #6 and #7.					
	Interview with the	ne RC on 12/13/12 at 4					
	PM indicated cli	ent #7 had a history of					
	non compliance						
	medications, "Bu	at it's his right to eat what					
	he wants." The F	RC stated the DCS were					
		he clients to follow the					
	· ·	clients chose not to eat					
	· · · · · · · · · · · · · · · · · · ·	"there's nothing we can					
		icated he had talked to					
		ocumenting the medical					
		neetings. The RC stated,					
	"	going to have to start					
	1	" The RC indicated client					
		nute checks due to his					
		nd his history of going					
	AWOL (absence	e witnout leave).					
	Interview with the	ne facility LPN (Licensed					
		on 12/13/12 at 9:30 AM					
	,	d not completed a					
		nent on clients #1, #2, #3,					
		7. The LPN indicated she					
	" 1, " 5, " 6 and #	, . The Diff indicated sile					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 70 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE S COMPL		
DIE	21 Columbia	15G225		LDING		01/08/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	1 50/	
NAME OF P	PROVIDER OR SUPPLIER			2234 Q			
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		any calls in regards to	+	1710			DATE
		n regards to any health					
		PN indicated she had					
		entation in clients #1's					
		The LPN indicated the					
	previous nurse h	ad quit the facility a					
	_	s earlier and she was only					
	trying to fill in u	ntil the facility could hire					
	a permanent nur	se. The LPN indicated					
	clients #1 and #7	did have Diabetic					
	protocols in their	r records but neither were					
	•	each client's specific					
	medical issues a	nd neither indicated the					
	_	formation nursing was to					
		The LPN indicated the					
		was to call the RC if					
	•	lem and then the RC					
	would notify the						
		d not received any calls					
		iny issues in regards to					
		7. The LPN indicated all					
		sugars were to be fasting					
	_	o the clients eating. The ne DCS were to follow					
		as the physicians had					
		N indicated the facility					
		nave a yearly PSA on all					
	-	ler. The LPN indicated					
		had a PSA since 2010.					
	cheme in a mad mot	. 1144 4 1 5/1 5/1100 2010.					
	9-3-6(a)						
	` '						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 71 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G225	B. WIN			01/08/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2234 Q			
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0369	assure that all dru are self-administe without error. Based on observe interview for 2 o observed being a failed to ensure a	rug administration must rugs, including those that ered, are administered ation, record review and f 25 medications administered, the facility all medications were hout error to clients #4	W0:	369	W 369 Drug Administration The system for drug administration must assure the all drugs, including those that a self-administered, are administered without error.		02/07/2013
	7am, client #4 w CIB (Carnation I cereal and toast a At 7:35am, DCS administered clie a medication blis indicated "Gemf (milligrams) 1 ta (one half hour) b Hypercholestrem #4's MAR (Medi Record indicated (milligrams) 1 ta (one half hour) b Hypercholestrem 7:40am, DCS #5	blet twice daily 1/2 hrs. before meal" for hia. At 7:40am, client fication Administration I "Gemfibrozil 600mg blet twice daily 1/2 hrs. before meal" for hia (high cholesterol). At indicated the medication belient #4 was the facility's			1. What corrective action will be accomplished? Staff will be retrained on the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 1-30-13. A medication practicum be done with Staff #5 by 2-7-1. How will we identify oth residents having the potentia to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficient practice.	will 3. er Il	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 72 of 105

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G225	A. BUII	LDING	ONSTRUCTION 00	(X3) DATE S COMPLE 01/08/2	ETED
NAME OF P	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAG	2. During observon 12/11/12 from client #6 consumbananas. At 6:50 his breakfast of the cereal. At 7:15a client #6 come to DCS #5 adminis "Levothroxine 1 (Synthroid) give half an hour beform 7:40am, DCS #5 medications were medication pass. Interview with the 12/13/12 at 9:30 medications were physician had pron the MAR. The the DCS were to medication with	vation at the group home in 6:15am until 6:40am, ited three (3) whole coam, client #6 consumed coast, milk, and cold im, DCS #5 requested to the medication room. itered client #6's il2mcg (micrograms) il tablet orally once a day one food" for thyroid. At indicated client #6's ite given the 7am are facility nurse on AM indicated all ite to be given as the escribed and as directed in facility nurse indicated		IAG	Random medication practicums will be completed staff to ensure that they are following the proper med pass procedures and the prescribe doctor's orders. Staff will be retrained of the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 1-30-13. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur: Random medication practicums will be completed staff to ensure that they are following the proper med pass procedures and the prescribe doctor's orders.	mic with	DATE
	three match. The the DCS should the discrepancy	facility nurse indicated have notified nursing of of not giving client #4 ions until after they had			Staff will be retrained of the medication administration pass procedures and the importance of following the physicians orders during their staff meeting on 1-30-13.		
					4. How will the corrective action be monitored to ensu the deficient practice will no recur?	re	

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00	COMPLETED 01/08/2013
NAME OF P	ROVIDER OR SUPPLIEF	R	2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG			TAG	The RC will monitor on daily basis when they are in the home. The Program Specialist monitor as they complete their audits. The What is the date by whith the systemic changes will be completed? Tebruary 7 th, 2013	a ne will r

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 74 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		15G225	B. WING 01/08/2013			01/08/2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			2234 Q		
OCCAZIO	O INC				ASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W0381	The facility must conditions of seci	E AND RECORDKEEPING store drugs under proper urity. ation and interview, for 1	W0	381		02/07/2013
		t #5) who had medication	'' '		W 381 Drug Storage and	02/07/2015
	,	*			Recordkeeping	
		he workshop by the				
	medication was	facility failed to ensure kept secure.			The facility must store drugs under proper conditions of security.	
	Findings include	:				
	Direct Care Staff workshop throug client #7 sat at a area. At 12noon clear plastic unle front of client #7 workshop floor a unlocked clear p and out of DCS insulin medicatic lancets were visic clear plastic box returned to the a unsecured insuli lancets. At 12:2 administered cliemedication. On 12/12/12 at 1 with the QMRP/Retardation Profession	. ,			1. What corrective action will be accomplished? Note- in the description how the standard was not met observation and interview references Client #5. In the findings section Client #7 is referenced. The incident described happened with Client #7, not Client #5. Staff will be retrained or the medication administration pass procedures and the importance of keeping medications secured on 1-30- A medication practicum be done with Staff #3 by 2-7-1 A box that can be secur will be purchased for Client #7 insulin. This box will be used when the insulin is taken on outings and to workshop.	nt 13. will 3.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 75 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	COMPLETED 01/08/2013
NAME OF	PROVIDER OR SUPPLIER O INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE PROPRIATE OF THE PROPRIA	E COMPLETION
140	Coordinator) was conducted. The QMRP/PD and the RC both indicated client #7's insulin medication should have been secured and was not once the staff walked away from the unsecured medication box. 9-3-6(a)	2. How will we identify oresidents having the potent to be affected by the same deficient practice and what corrective action will be ta All residents have the potential to be affected by the same deficient practice. Staff will be retrained the medication administration pass procedures and the importance of keeping medications secured on 1-3 A medication practiculate be done with Staff #3 by 2-7 A box that can be seed will be purchased for Client insulin. This box will be used when the insulin is taken on outings and to workshop. 3. What measures will be put into place or what systing the same deficient practiculate the process of the pro	other itial t ken? e ne on on on 0-13. em will '-13. cured #7's d
		changes will be made to ensure that the deficient practice does not recur: Staff will be retrained	on
		the medication administration pass procedures and the importance of keeping medications secured on 1-3 A medication practiculate be done with Staff #3 by 2-7	0-13. ım will

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 76 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING		COMPLETED 01/08/2013	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO) INC		2234 Q NEW C	AVE ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				A box that can be secur will be purchased for medication that need to be transported. To box will be used when the institute is taken on outings and to workshop.	ons his	
				4. How will the corrective action be monitored to ensur the deficient practice will not recur?		
				The RC will monitor on daily basis when they are in th home.		
				The Program Specialist monitor as they complete their audits.		
				5. What is the date by whi the systemic changes will be completed? February 7 th , 2013		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 77 of 105

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) !		(X2) M	X2) MULTIPLE CONSTRUCTION (X.			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING 00		COMPL	ETED
		15G225	B. WIN			01/08/	2013
j			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				2234 Q			
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0426	where clients who regulate water ter hot water, ensure water does not ex Fahrenheit. Based on observe interview, the fact sampled clients (#4) and 4 addition #6, #7, and #8), to of the water did in Fahrenheit. Findings include	in areas of the facility to have not been trained to imperature are exposed to that the temperature of the acced 110 degrees ation, record review, and cility failed for 4 of 4 (clients #1, #2, #3, and onal clients (clients #5, to ensure the temperature not exceed 110 degrees	WO	426	W 426 Client Bathrooms The facility must, in areas of the facility where clients who have been trained to regulate the watermperature are exposed to howater, ensure that the temperature of the water does exceed 110 degrees Fahrenheed.	not ater ot not	02/07/2013
	12/10/12 between temperature of the betoo hot to keen it for routine hand rising from the statemperature was north bathroom at to be 128 degreen temperature was south bathroom at found to be 128 During observation 12/11/12 from 5:	taken at 6:15 PM in the at the tub and was found as Fahrenheit. The water taken at 6:20 PM in the at the shower and was 5 degrees Fahrenheit.			1. What corrective action will be accomplished? The water temperature if the home has been adjusted by to 110 degrees Fahrenheit. Staff is to complete water temperature checks three times week and document the finding on the water temperature checks sheet in Therap. Temperatures above 110 degrees Fahrenheit are reported to the RC for the home. Staff will be retrained on the importance of checking these	ack er s a gs ck s	
	-	ne water was measured Staff (DCS) #5 and DCS			water temperature and reporting temperature concerns to the R during their team meeting on	ng	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 78 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G225	B. WIN	G		01/08/2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
				2234 Q		
OCCAZIO	O INC			NEW C	ASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	#6 as follows:				1-30-13.	
	•	chen sink was 126.9			· Water temperature	
	degrees Fahrenh	eit.			assessments will be complete	d
	-At 6am, bathroo	om #1 was 132.6 degrees			with Client #1, #2, #3, #4, #5,	#6
	Fahrenheit.				and #7. (Note there was not a	
	-At 6:05am, the	handsink in the			client #8 at the time of the	
	medication room	was 132.7 degrees			survey).	
	Fahrenheit.				· The IPOP assessments	will
					be updated to reflect Client's	#1 ,
	On 12/11/12 at 1	2:05pm, the QDP			#2, #3, #4, #5, #6, and #7's	
	(Qualified Disab	ilities Professional) was			abilities to regulate water	
	` `	e QDP stated clients #1,			temperatures.	
		6, and #7 "did not				
		ks of hot water." The				
		nonitoring of the group			2. How will we identify oth	
	home water temp				residents having the potentia	al
	1	e overnight staff and the			to be affected by the same	
		•			deficient practice and what corrective action will be take	n2
		re was not to exceed 110			corrective action will be take	
	degrees Fahrenh	en.			· All residents have the	
					potential to be affected by the	
					same deficient practice.	
					Staff is to complete wat	er
					temperature checks three time	
					week and document the finding	
					on the water temperature che	
					sheet in Therap. Temperature	
				above 110 degrees Fahrenhe are reported to the RC for the	11	
					home.	
					Staff will be retrained or	
					the importance of checking the	
					water temperature and reporti	
					temperature concerns to the F during their team meeting on	
					1-30-13.	

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00	COMPLETED 01/08/2013
NAME OF P	ROVIDER OR SUPPLIEF		2234 0	ADDRESS, CITY, STATE, ZIP CODE Q AVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				The IPOP assessments and water temperature assessments will be reviewed and updated as the resident's needs change.	
				3. What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur:	nic
				Staff is to complete wat temperature checks three time week and document the findin on the water temperature che sheet in Therap. Temperature above 110 degrees Fahrenhe are reported to the RC for the home.	es a gs ck s
				 Staff will be retrained of the importance of checking the water temperature and reporting temperature concerns to the Feduring their team meeting on 1-30-13. 	e ng
				The IPOP assessments and water temperature assessments will be reviewed and updated as the resident's needs change.	
				4. How will the corrective action be monitored to ensu the deficient practice will no	-

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 80 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING	00	COMPLETED 01/08/2013
NAME OF	PROVIDER OR SUPPLIEI O INC		2234 C	ADDRESS, CITY, STATE, ZIP CODE AVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Client #1's recor 12/11/12 at 11 A did not indicate water temperatu Client #2's recor 12/12/12 at 11 A did not indicate water temperatu Client #3's recor 12/11/12 at 2:15 did not indicate water temperatu	rd was reviewed on AM. The client's record client #1 could adjust the re within the group home. rd was reviewed on AM. The client's record client #2 could adjust the re within the group home. rd was reviewed on AM. The client's record client #2 could adjust the re within the group home. rd was reviewed on AM. The client's record client #3 could adjust the re within the group home.		recur? The RC will monitor on daily basis when they are in the home. The Program Specialist monitor as they complete their audits. The Maintenance Direct will also monitor as he complete his checks. 5. What is the date by white the systemic changes will be completed? February 7 th , 2013	a ne will r tor etes

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 81 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G225	A. BUILDING B. WING		COMPLETED 01/08/2013
NAME OF I	PROVIDER OR SUPPLIER	2234 C	ADDRESS, CITY, STATE, ZIP CODE NAVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	12/12/12 at 1:35PM. The client's record did not indicate client #4 could adjust the water temperature within the group home. Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:30 PM indicated the temperature of the water in the group home was not to be above 110 degrees Fahrenheit. Interview with the PS (Program Specialist) on 12/12/12 at 1 PM indicated the temperature of the water in the group home was not to exceed 110 degrees Fahrenheit. 9-3-7(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 82 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLI	ETED
		15G225	B. WIN			01/08/	2013
			р. WIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2234 Q			
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0429	and humidity with by heating, air co Based on observ of 7 clients (clien in the group hom maintain heat ab	maintain the temperature in a normal comfort range nditioning or other means. ation and interview, for 3 ants #3, #4, and #5) living he, the facility failed to ove 68 degrees F de the client bedrooms.	WO	429	W 429 Heating and Ventilatio The facility must maintain the temperature and humidity with normal comfort range by heati air conditioning or other means	in a ng,	02/07/2013
	completed at the observation clier bedroom doors we fam, DCS (Direct DCS #6 both indepropped open to bedrooms. At 6: "My room is cold temperature read At 6:25am, clien bedroom air temperature read his bedroom "was #4 stated "You collent #4's bedroopen to the hallwork Interview with the Specialist) on 12	62 degrees Fahrenheit. t #3 and #4's shared perature was 60 degrees 5:30am, client #4 stated as always cold." Client an see your breath."			1. What corrective action will be accomplished? A service call was completed by the Heating and Cooling company used by Occazio on 1-22-13. It was fou during the service call that the vents in Client #3, #4, and #5's bedrooms were closed. The vents have now bedropened. Leading the potential to be affected by the same deficient practice and what corrective action will be take same deficient practice.	en er II	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 83 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUILDING B. WING	00 	COMPLETED 01/08/2013	
NAME OF P	PROVIDER OR SUPPLIER		2234 C	ADDRESS, CITY, STATE, ZIP CODE Q AVE CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) This.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) ensure that the vents remain open so that a proper temperature can be maintaine within the rooms.	DATE
				Temperature concerns be reported to the Maintenand Director. The Heating and Coolir equipment within the home wis serviced on a regular basis to ensure that it is operating properly.	g g
				3. What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur: The RC and/or DSA will ensure that the vents remain open so that a proper temperature can be maintained within the rooms.	I
				Temperature concerns be reported to the Maintenand Director. The Heating and Coolir equipment within the home wis serviced on a regular basis to ensure that it is operating properly. How will the corrective	g g

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 84 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING		COMPLETED 01/08/2013	
NAME OF P	ROVIDER OR SUPPLIER		2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
				action be monitored to ensur the deficient practice will not recur?		
				The RC will monitor on daily basis when they are in the home.		
				The Program Specialist monitor as they complete their audits.		
				The Maintenance Direct will also monitor as he comple his checks.		
				5. What is the date by whi the systemic changes will be completed?		
				February 7 th , 2013		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 85 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	ETED
		15G225	B. WIN			01/08/2	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			2234 Q			
OCCAZI					ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0436	repair, and teach informed choices eyeglasses, heard communications a devices identified team as needed to Based on observinterview, for 2 c (clients #3 and # equipment prescribed eye good client #4's wheel Findings include	furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client. ation, record review, and of 4 sampled clients 4) who had adaptive ribed, the facility failed to rage client #3 to wear his lasses and failed to ensure chair was in good repair.	WO	436	W 436 Space and Equipment The facility must furnish, maint in food repair, and teach client use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aid braces, and other devices identified by the interdisciplinat team as needed by the client.	tain s to s,	02/07/2013
	on 12/10/12 betwon 12/11/12 from client #3 was not During this time Care Staff) #5 ar prompt client #3 Client #3's record 12/11/12 at 2:15/1:40pm. Client #assessment indic prescribed eye girecommendation waking hours. C (Individual Supp	vations at the group home veen 4 PM and 7 PM and in 5:55am until 8:35am, it wearing any eyeglasses. period the DCS (Direct and DCS #6 did not to wear his glasses. d was reviewed on pm, and on 12/12/12 at #3's 11/1/11 vision ated client #3 had lasses and a to wear them during Client #3's 4/3/12 ISP Fort Plan) did not indicate to wear his glasses.			1. What corrective action will be accomplished? Client #3 will be put on programming to encourage hir wear his eye glasses. Client #3's ISP will be updated to reflect the need to wear his eye glasses. Staff will be retrained or 1-30-13 during their team meeting on the importance of ensuring adaptive equipment i available, in good repair and to encourage the residents to util the equipment.	s o	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 86 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G225	B. WIN			01/08/2013	
NAME OF P	PROVIDER OR SUPPLIEF	2		2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	On 12/13/12 at 1 conducted with the Developmental I indicated client in glasses. The QL not have a format glasses. The QL should have been to wear his present on 12/10/12 between 12/11/12 from client #4 sat in high the two arm rest duct tape. On 12/11/12 at 1 was reviewed. On indicated he used ambulation. On 12/13/12 at 1 the QDP was condicated client in the two arms are condicated client in the two arms.	I lam, an interview was the QDP (Qualified Professional). The QDP #3 had prescribed eye DP indicated client #3 did al goal to wear his eye DP indicated client #3 In taught and encouraged cribed eyeglasses. vations at the group home ween 4 PM and 7 PM and In 5:55am until 8:35am, It is wheelchair and one of Is was held in place with I:35pm, client #4's record Client #4's 9/12/12 ISP I a wheelchair for I lam, an interview with Inducted. The QDP #4's wheelchair had duct the arm rest in place. Ited he was not aware of			Client #4 has a new wheelchair that has been ordered. It should arrive before 2-7-13. How will we identify off residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. All residents have the potential to be affected by the same deficient practice. Staff will be retrained or 1-30-13 during their team meeting on the importance of ensuring adaptive equipment available, in good repair and to encourage the residents to util the equipment. The residents IPOP assessments will be reviewed and updated as their needs change. Programming will be implemented based on the residents assessments and as their needs change.	erall n?	
	wheelchair. 9-3-7(a)				3. What measures will be put into place or what syster changes will be made to ensure that the deficient	nic	

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	ETED
		15G225	B. WING	Ü		01/08/	2013
			_	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R		234 Q /			
OCCAZIO	O INC				ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	\G	DEFICIENCY)		DATE
					practice does not recur:		
					Staff will be retrained or 1-30-13 during their team meeting on the importance of ensuring adaptive equipment available, in good repair and to encourage the residents to util the equipment.	is O	
					The residents IPOP assessments will be reviewed and updated as their needs change.		
					Programming will be implemented based on the residents assessments and as their needs change.	S	
					4. How will the corrective action be monitored to ensur the deficient practice will not recur?	t	
					The RC will monitor on daily basis when they are in the home.		
					The Program Specialist monitor as they complete their audits.		
					5. What is the date by whi the systemic changes will be completed?		
					February 7 th, 2013		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 88 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		15G225	A. BUIL B. WING			01/08/2013	
NAME OF F	ROVIDER OR SUPPLIE D INC	ER		2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W62X11 Facility ID: 000749 If continuation sheet Page 89 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G225	B. WING		01/08/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R	2234 G		
OCCAZIO) INC			CASTLE, IN 47362	
			INEW C	CASTLE, IN 47302	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0440	483.470(i)(1)				
	EVACUATION D				
		hold evacuation drills at			
		or each shift of personnel.			
	Based on record	d review and interview, the	W0440		02/07/2013
	facility failed for	or 4 of 4 sampled clients		W 440 Evacuation Drills	
	(#1, #2, #3 and	#4) and 3 additional		The feedlife and the little	
		and #7), by not ensuring		The facility must hold evacuat	
		rill was conducted at least		drills at least quarterly for each shift of personnel.	11
		or the day shift (7 AM - 3		Silit of personner.	
	1 ,	•			
	PM) during 201	2.			
				1. What corrective action	
	Findings includ	e:		will be accomplished?	
				•	
	The facility's ev	acuation drills were		· A day shift drill will be ru	un
	1	/12/12 at 1 PM. The		by 2-7-13.	
		d the facility had failed to		· The importance of ensu	•
	conduct evacuat	tion drills for clients #1,		that evacuation drills are ran a	
	#2, #3, #4, #5, #	#6, and #7 for the period		least quarterly for each shift of	
	between 4/14/12	2 at 2pm and 10/13/12 at		personnel will be reviewed wit	
		y shift personnel.		the staff and RC during their to meeting on 1-30-13.	eam
	2011, 101 1110 442	y sinit personner.		Theeting on 1-30-13.	
	T	I DC (D		A drill tracking sheet wil	l he
		the PS (Program		utilized by the RC and DSA to	I
	Specialist) on 12	2/12/12 at 1 PM indicated		ensure that drills for each shift	
	she was unable	to locate any further		personnel are being conducted	I
	evacuation drill	s for clients #1, #2, #3, #4,			
	#5, #6, and #7.				
	-, -,				
	0.2.7(a)			2. How will we identify oth	I
	9-3-7(a)			residents having the potential	al
				to be affected by the same	
				deficient practice and what	_
				corrective action will be take	n?
				All manidants bases !!	
				 All residents have the potential to be affected by the 	
				same deficient practice.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 90 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	00	COMPLETED		
		15G225	B. WING		01/08/2013		
NAME OF P	ROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
				The importance of entithat evacuation drills are ran least quarterly for each shift personnel will be reviewed with the staff and RC during their meeting on 1-30-13. A drill tracking sheet with the RC and DSA ensure that drills for each shippersonnel are being conductions.	n at of vith r team will be to hift of		
				3. What measures will be put into place or what systechanges will be made to ensure that the deficient practice does not recur: The importance of enthat evacuation drills are rareleast quarterly for each shift personnel will be reviewed with the staff and RC during their meeting on 1-30-13. A drill tracking sheet witilized by the RC and DSA ensure that drills for each shippersonnel are being conductive.	suring n at of vith r team will be to nift of		
				4. How will the corrective action be monitored to ensith the deficient practice will not recur? The RC will monitor of daily basis when they are in	oot no a		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 91 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING		COMPLETED 01/08/2013			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE					
OCCAZIO			NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				home. The Program Specialist monitor as they complete their audits.				
				5. What is the date by whi the systemic changes will be completed? February 7 th , 2013				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 92 of 105

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		15G225	B. WIN			01/08/2	2013
NAME OF B	ADOLUDED OD GUDDI IED	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2234 Q	AVE		
OCCAZIO	O INC			NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
W0460		LSC IDENTIFYING INFORMATION)	1	IAG	DLI ICILICE I		DATE
VVU 4 60	483.480(a)(1)	RITION SERVICES					
		receive a nourishing,					
		t including modified and					
	specially-prescrib	ed diets.					
	Based on observ	ation, interview and	W04	460			02/07/2013
	record review fo	r 4 of 4 sampled clients			W 460 Food and Nutrition		
	(#1, #2, #3 and #	44), and 3 additional			Each client must receive a		
	clients (#5, #6 ar	nd #7), the facility failed			Each client must receive a nourishing, well-balanced diet		
	to ensure the DC	S (Direct Care Staff)			including modified and special		
		ility menu and provided			prescribed diets.		
		ns for food not eaten.					
	chefit substitutions for food not catch.						
	Findings include	:			What corrective action will be accomplished?		
	12/10/12 betwee clients #1, #2, #3 eating their even meal consisted o broccoli/cauliflo	ions at the group home on n 4 PM and 6:30 PM, 8, #4, #5, #6 and #7 were ing meal. The evening f oven fried chicken, wer mix, mashed t cocktail with water and			Regular meal observation will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans.	0	
	portions of every assisted client #7 filling their plate up the breading of chicken off of the	Client #7 took double withing. While the staff r's housemates with es, client #7 began picking crumbs of oven fried e plate of chicken and			Staff will be retrained or Client #1, #2, #3, #4, #5, #6, a #7's dining plans, how to provi appropriate food substitutions the importance of following the menu at their staff meeting on 1-30-13.	ind ide and	
	the skin off of th had placed on hi that. Client #1 pl broccoli and cau	ent #7 then began pulling e 2 pieces of chicken he s plate and began eating aced a serving of liflower on his plate but 5 PM clients #1, #2, #3,			Client #1, #2, #3, #4, #5 #6, and #7 will be placed on programming to follow their die All of the menus prescri for the clients will be available within the home for staff to follow.	et. bed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 93 of 105

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	DINC	00	COMPLE	ETED
		15G225	A. BUII B. WIN			01/08/2	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
000471	O INO			2234 Q			
OCCAZIO	JINC			NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#4, #5 and #6 ha	d eaten their meals and					
	left the table. Cl	ient #7 remained at the			 The dietician completed 		
	table and continued to eat. DCS #12				her quarterly evaluations for th		
		he table of the remaining			home on 1-24-13. Upon receiv	_	
	"	•			her recommendations, the IDT		
		asked client #7 if he			will review and implement the recommendations accordingly		
		of the mashed potatoes			Teconimendations accordingly	•	
	and put the remaining mashed potatoes				· Client #7 attended week	_{dv}	
	onto client #7's p	plate. While doing so			diabetic education classes. His		
	DCS #12 stated,	"You shouldn't eat so			last class was scheduled for		
	much because it will raise your blood sugar." Throughout the evening meal the DCS did not prompt client #7 on appropriate serving sizes. Clients #1, #2,				1-23-13.		
					2. How will we identify oth		
					residents having the potentia		
		nd #7 were not offered			to be affected by the same	"	
	bread, margarine	e or milk during this		deficient practice an			
	observation or a	n equal substitution. The			corrective action will be taken?		
	DCS did not offe	er client #1 a substitution					
	for the broccoli/o	cauliflower mix he did			· All residents have the		
	not eat.				potential to be affected by the		
					same deficient practice.		
	On 12/11/12 f	m 5:55am until 8:35am,					
		· · · · · · · · · · · · · · · · · · ·			Regular meal observation	ons	
		served at the group home.			will be completed by the RC and/or the DSA for the home t	_	
		ned his breakfast of a			ensure that the menu is being	~	
	banana, milk, jui	ice, cold cereal, toast, and			followed and that staff are		
	two bags of mice	rowave popcorn. At			encouraging the residents to		
	7:55am, Direct (Care Staff #5 assisted			follow their prescribed dining		
	client #7 to pack	his lunch box with three			plans.		
	_	we popcorn inside. DCS			0		
	_				Staff will be retrained or		
	#5 indicated client #7 took this lunch box and a second lunch box was brought to the workshop at noon daily for his				Client #1, #2, #3, #4, #5, #6, a #7's dining plans, how to provi		
					appropriate food substitutions		
					the importance of following the		
	consumption after	er his noon blood sugar.			menu at their staff meeting on		
					1-30-13.		
	On 12/11/12 from	m 10:35am until					

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	15G225		A. BUILDING B. WING			COMPLETED 01/08/2013	
NAME OF P	ROVIDER OR SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12:20pm, observe were completed at 10:35am until 12 into and out of the break area and from the ext classroom. It is 12 into an and out of the break area and from the ext classroom. It is 12 into an and out of the ext classroom. It is 12 into an an area and from the ext classroom. It is 12 into an area and the ext is 12 into an area and the ext is 12 into an area and check is 12 into an area and are	ations and interviews at the workshop. From noon, client #7 walked we workshop area, the om one classroom to the From 10:35am until fixed his own bag of orn and consumed it throughout the at #7 walked into and out front area of the we lobby area. At beta stated "I eat about 4 to on when I'm here a day." on the #7's Workshop So indicated client #7 did of microwave popcorn of workshop a day" and of iting for the facility staff of check for [client #7's] of the facility staff of the facilit		TAG	All of the menus prescrit for the clients will be available within the home for staff to follow the put into place or what system changes will be made to ensure that the deficient practice does not recur: Regular meal observation will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. Staff will be retrained on Client #1, #2, #3, #4, #5, #6, a #7's dining plans, how to proviappropriate food substitutions the importance of following the menu at their staff meeting on 1-30-13. All of the menus prescrit for the clients will be available within the home for staff to follow	bed bw. nic nns nd de and e	DATE
	12/10/12 at 6 PM provided for revigroup home was 1800 KCAL(kild 10/7/09. The men	nus were reviewed on I. The only menu ew being used in the the facility's Fall/Winter calorie's) menu dated nu indicated for the			4. How will the corrective action be monitored to ensur the deficient practice will not recur?	-	
	evening meal on to have:	12/10/12 the clients were			The RC will monitor on a daily basis when they are in the		

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G225	B. WIN			01/08/2013
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	C		2234 Q	AVE	
OCCAZIO	O INC			NEW C	ASTLE, IN 47362	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	3 ounces of m				home.	
	1/2 cup of mashed potatoes or 1/2 cup				· The Program Specialist	will
	of cooked corn				monitor as they complete their	
	1 cup of green				audits.	
	1 slice of bread with 1 teaspoon of					
	margarine					
	1/2 cup of mandarin oranges				5. What is the date by which	ch
	1 cup of water	ſ			the systemic changes will be	
	1 cup of skim	or 1/2 % milk			completed?	
	8 to 12 ounces of sugar free punch The menu indicated the morning meal on					
					February 7 th , 2013	
		ents were to have:				
	1/2 cup of app					
	$\frac{1}{2}$ cup of sci	_				
		ole wheat toast with 1				
		garine and 1 teaspoon of				
	sugar free jelly	garme and 1 teaspoon of				
	1 cup of water	-				
	1 cup of skim	or 1/2 % milk				
	Review of the Fa	ood Substitution Record				
		12 on 12/10/12 at 6 PM				
		ff had substituted chicken				
	for meatloaf and					
		wer. The record indicated				
		e substitution was the				
		The record failed to				
		titution of the mandarin				
	oranges for the f	ruit cocktail.				
	Client #1's recor	d was reviewed on				
	12/11/12 at 11 A	M. The client's 8/29/12				
	ISP (Individual S	Support Plan) indicated				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 96 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
ANDILAN	OI COMMECTION	15G225		LDING		01/08/		
		100220	B. WIN		ADDRESS STATE THE SORE	0 17007	2010	
NAME OF F	PROVIDER OR SUPPLIER			2234 Q	ADDRESS, CITY, STATE, ZIP CODE			
OCCAZIO	O INC				ASTLE, IN 47362			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ROPRIATE		
IAG		,		TAG	DEFECENCE!)		DATE	
		liagnosis of, but not						
	· ·	n dependent Diabetes. ndicated client #1						
		f to make sure healthy						
	-							
		able for him to help him od sugar levels." Client						
		MAR (Medication						
		Record) indicated the						
		Renal Calorie Diet" and						
	could have secon							
		etables and protein. The						
		ated client #1 was on a						
		at no concentrated						
	_	e client's quarterly						
		of 2/6/12 indicated the						
		ered the 1800 KCAL						
		‡1 to lower his potassium						
		cian indicated she had						
		00 KCAL, low potassium						
	_	elient #1 with his renal						
	diet. Review of t	he facility menus did not						
	indicate a low po	otassium menu for client						
	#1.							
	Client #7's recor	d was reviewed on						
	12/12/12 at 2 PM	I. Client #7's ISP of						
	4/3/12 indicated	the client was "quite						
	obese" and was	diabetic "with increasing						
	problems with co	ontrolling his high blood						
	sugars." The clie	ent's Heath Care Reports						
		e the client was to follow						
	a diabetic diet. T	The November 2012						
	-	ort indicated client #7						
	weighed 301 por	ınds.						
							<u> </u>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 97 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:			00	COMPL	
15G225		A. BUII B. WIN	LDING	01/08/2013			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER			2234 Q			
OCCAZIO	O INC			NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	Intomvious svith o	lient #1 on 12/10/12 at					
		ed he did not eat his					
		wer mixture, because he					
		nen asked if the DCS had					
		thing in place of the					
	_	wer mixture the client					
		e client indicated he					
	, ,	d to have something else					
		egetables that were					
	offered.	8					
	Interview with D	OCS #14 and #12 on					
	12/10/12 at 6 PM	I indicated DCS #12 did					
	not know which	menu he was to be					
	following in the	preparation of the					
	evening meal. D	CS #14 indicated because					
	a family member	r had brought food into					
	the home for a p	revious meal and due to					
	lack of food in the	ne home and the need to					
	go shopping, the	Monday evening menu					
	had been substitu	uted for a Sunday lunch.					
		ted the Fall/Winter 1800					
		s the only menu in the					
		e that was followed for					
	clients #1, #2, #3	3, #4, #5, #6 and #7.					
	Internia 14 4	on DC (Desidential					
		ne RC (Residential					
		12/13/12 at 4 PM					
		#7 had a history of non					
	_	his diet, "But it's his					
		he wants." The RC stated					
		"encourage" the clients nu, but if the clients					
	to follow the file	inu, out ii uic chellis					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 98 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		15G225	B. WING		01/08/2013	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
OCCAZIO	OCCAZIO INC			AVE ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		the food offered, "there's				
	nothing we can	do."				
	Interview with	the RC (Residential				
		12/12/12 at 2 PM				
	· ·	CS are to offer all of the				
		enu or to provide a like				
		e food not offered.				
	9-3-8(a)					
			1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 99 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER: 15G225	A. BUILDING B. WING			COMPLETED 01/08/2013	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG W0488	483.480(d)(4) DINING AREAS A	AND SERVICE assure that each client eats istent with his or her	W0		W 488 Dining Areas and Service The facility must assure that eclient eats in a manner consist with his or her developmental level. 1. What corrective action will be accomplished? • Staff will be retrained or ensuring active treatment and meal preparation process durit their team meeting on 1-30-13 • Programming will be purplace for Clients #1, #2, #3, and #4 to increase their independe with meal preparation. • The ISP for Clients #1, #3, and #4 will be updated to include objectives to participat meal preparation. 2. How will we identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take	ent the ng tin nd nce #2, e in	02/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 100 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUILDING B. WING		COMPLETED 01/08/2013				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				All residents have the potential to be affected by the same deficient practice.				
				Regular meal observation will be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans. Staff will be retrained on Client #1, #2, #3, #4, #5, #6, a #7's dining plans, how to provappropriate food substitutions the importance of following the menu at their staff meeting on 1-30-13. All of the menus prescrifor the clients will be available within the home for staff to following the formula to the staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home for staff to following the menus prescrifor the clients will be available within the home	n and ide and e			
				3. What measures will be put into place or what syster changes will be made to ensure that the deficient practice does not recur: Regular meal observativill be completed by the RC and/or the DSA for the home to ensure that the menu is being followed and that staff are encouraging the residents to follow their prescribed dining plans.	ons o			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 101 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	of Deficiencies (X1) Provider/Supplier/CLIA (X1) Provider/Supplier/CLIA (DENTIFICATION NUMBER: 15G225	A. BUILDING	00	COMPLETED 01/08/2013
NAME OF P	ROVIDER OR SUPPLIER	2234 Q	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
			Staff will be retrained of Client #1, #2, #3, #4, #5, #6, #7's dining plans, how to provappropriate food substitutions the importance of following the menu at their staff meeting or 1-30-13. All of the menus prescriptor the clients will be available within the home for staff to for	and vide s and e n ribed
			4. How will the corrective action be monitored to ensu the deficient practice will no recur?	ire
			The RC will monitor on daily basis when they are in thome.	
			The Program Specialis monitor as they complete the audits.	I
			5. What is the date by wh the systemic changes will b completed?	I
	Based on observation, interview and record review, the facility failed to assur 4 of 4 sampled clients (clients #1, #2, #3 and #4) assisted in their meal preparation		February 7 th , 2013	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 102 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G225		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted '2013		
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	During observation 12/10/12 between evening meal of broccoli with carpotatoes and fruit by DCS (Direct At 5:30 PM, clied were sitting at the meal. During the was being preparation or standing at the watching the starmeal. Clients #2 wheel chairs at catable and not inverse preparation. Client he kitchen severe observation. The not involve client the evening mean provide them transpreparation. Client #1's recorming 12/11/12 at 11 Area (Individual Complan) of 9/12/12 not know how to foods. Client #2's recorming the evening means are provided them transpreparation.	ions at the group home on in 4 PM and 6:30 PM, the pre-baked oven chicken, aliflower, mashed it cocktail was prepared Care Staff) #11 and #12. Ints #1, #2, #3 and #4 is table for their evening in time the evening meal red client #1 was sitting in or near the dining room and #4 were sitting in or near the dining room rolved in the meal int #3 was in and out of real times throughout the PDCS #11 and #12 did its #1, #2, #3 and #4 with all preparation or to ining in regards to food in the meal in the preparation or to ining in regards to food in the preparation or to ining in regards to food in the preparation or to ining in regards to food in the preparation or to ining in regards to food in the preparation or to ining in regards to food in the preparation or to ining in regards to food in the prep						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 103 of 105

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 15G225	A. BUII	BUILDING 00 WING		COMPLETED 01/08/2013	
NAME OF PROVIDER OR SUPPLIER OCCAZIO INC			p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE AVE ASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)		'E	(X5) COMPLETION DATE	
		d client #2 required staff and cook simple foods.					
	12/11/12 at 2:15 ₁ 1:40pm. Client #	d was reviewed on om and on 12/12/12 at #3's 8/28/12 ICAP #3 did not know how to apple foods.					
	12/11/12 at 1:35 ₁ ICAP indicated chow to mix and control of the second	d was reviewed on om. Client #4's 9/12/12 client #4 did not know cook simple foods and er hand assistance by					
	Interview with DCS (Direct Care Staff) #13 on 12/10/12 at 6:40 PM indicated clients #1, #2, #3 and #4 required assistance with meal preparation and could not independently prepare a simple meal.						
	Coordinator) on indicated clients independently prindicated the DC	ne RC (Residential 12/13/12 at 4 PM #1 and #2 could not of epare a meal. The RC S were to involve the meal preparations.					
	the DCS are to o	ne PS (Program /12/12 at 1 PM indicated ffer all clients formal and at every available					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet Page 104 of 105

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15G225	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 01/08	LETED		
NAME OF F	PROVIDER OR SUPPLIE DINC	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2234 Q AVE NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	opportunity.							
	opportunity. 9-3-8(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W62X11

Facility ID: 000749

If continuation sheet

Page 105 of 105